Supreme Court, U.S.
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No. 10 - _____

IN THE
Supreme Court of the United States

RODNEY MILLER,

Petitioner,

v.

MONUMENTAL LIFE INSURANCE COMPANY,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Can an ERISA insurer, after denying an ERISA claim on one basis at the administrative level, assert a new defense on appeal to the District Court?

RULE 14.1(b) STATEMENT

A list of all parties to the proceeding in the court whose judgment in the subject of the petition is as follows:

Plaintiff/Appellant and Petitioner: Rodney Miller

Defendant/Appellee and Respondent: Monumental Life Insurance Company

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PETITION FOR WRIT OF CERTIORARI

Petitioner Rodney Miller respectfully petitions for a writ of certiorari to review the opinion and judgment of the United States Court of Appeals for the Tenth Circuit.

OPINIONS BELOW

The decision of the United States Court of Appeals for the Tenth Circuit is unpublished but reported at 2010 U.S. App. LEXIS 8795 and is reproduced in the appendix at pages 85-93. The decision of the United States District Court for the District of New Mexico is unpublished but reported at 2009 U.S. Dist. LEXIS 43859 and is reproduced in the appendix at pages 1-83.

JURISDICTION

The judgment of the court of appeals sought to be reviewed was issued on April 28, 2010. The petition is timely under Supreme Court Rule 13.1 because it is being filed within 90 days after the entry of the court of appeals' opinion and judgment. This Court has jurisdiction to review the judgment of the United States Court of Appeals for the Tenth Circuit pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISION INVOLVED

§ 1133. Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall--

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

STATEMENT OF THE CASE

The issue presented is whether the Defendant/Respondent Monumental Life Insurance Company can raise a new defense to an ERISA claim for the first time on appeal to the District Court.

On September 15, 1997, Petitioner Rodney Miller ("Miller") was injured in motor vehicle accident while in the course and scope of his employment with Aycock Transportation. Subsequently, Petitioner filed a claim for Long-Term Disability ("LTD") benefits under ERISA policy issued by Respondent Monumental Life Insurance Company. ("Monumental"). As required by the terms of the policy, Miller filed a disability claim with the Social Security Administration. After a hearing, the Administrative Law Judge determined that

Miller was disabled under Title XVI of the Social Security Act. After receiving the decision, Monumental nevertheless denied Miller's claim on the basis that it was not a "Social Security Disability Award" The denial letter read in full as follows:

> Based on a review of your policy terms it does not appear that you are eligible for continuous total disability.
>
> According to the terms of the policy in order to be eligible for continuous total disability you must be unable to engage in any gainful employment for which you can be reasonably trained for [sic].
>
> You must be awarded a social security disability award for injuries sustained from this accident of 9-15-97. The information you have provided to us from the social security office is for supplemental security income and not a social security disability award. Therefore, no benefits are available.

Thus, according to Monumental, and despite the absence of any differentiating language in the policy, Miller was required to obtain a Social Security Disability Award under Title II of the Social Security to meet the

disability requirements of the policy and because the decision of the Social Security Administrative Law Judge was under Title XVI, Miller was denied LTD benefits.

Miller appealed the denial to the United States District for the District of New Mexico and subsequently moved for Summary Judgment. Monumental filed a Cross-Motion for Summary Judgment, asserting for the first time on appeal that, in addition to the alleged failure to obtain a "Social Security Disability Award,: Miller's disability did not result "solely and directly from Injury" as set out in the policy. Prior to the District Court appeal, Monumental never asserted this policy defense to Miller.

On June 30, 2005, the District Court entered summary judgment in favor of Monumental, holding that the Social Security Administration's determination of disability under Title XVI of the Social Security Act did not constitute a "Social Security Disability Award" under the policy. The District Court did not address Monumental's newly-raised "sole cause" defense, determining that it "need not decide whether the other grounds that Monumental advances also preclude payment."

Miller appealed to the United States Court of Appeals to the Tenth Circuit. After receiving the parties' briefs, the appeals court ordered supplemental briefing on six specific questions and *sua sponte* determined that oral argument should be held. On September 25, 2007, the

Tenth Circuit reversed the decision of the District Court, holding that Miller met the policy requirement that he obtain a "Social Security Disability Award." However, the Tenth Circuit ordered a remand because the District Court did not address Monumental's argument that Miller's accident was not the sole cause of his disability.

On the sole cause remand, the District Court allowed supplemental briefing and held oral arguments over Miller's objections that the sole cause issue was untimely and its application would not change the outcome. On March 31, 2009, the District Court ordered a remand to the Plan Administrator to allow Monumental to develop the "sole cause" defense that it first asserted at the District Court appeal. According to the District Court:

> The problem in this case is that the Plan Administrator gave only one basis for denying benefits and was silent on the other elements of the Policy. The record does not reflect that the Plan Administrator determined whether the work injury was the sole cause of the disability or whether she believed evidence on that element was lacking. Until the Plan Administrator clarifies at what evidence it looked on the sole cause and other elements, the Court cannot review what the

> Plan Administrator did in a meaningful way.

Miller v. Monumental Life, 2009 U.S. Dist. LEXIS 43859 at 91-92, App. at 60 (D.N.M. 2009).

In response to this decision, Miller filed a second appeal to the Tenth Circuit, raising the issue of whether Monumental was permitted to raise a defense for the denial of an ERISA claim for the first time at the District Court level. On April 28, 2010, the Tenth Circuit held that due to a lack of finality, it lacked jurisdiction to review the decision of the District Court to remand the "sole cause" issue to the Plan Administrator. According to the Tenth Circuit,

> While it is conceivable that Miller may ultimately convince either this court or the district court that Monumental was barred from raising the 'sole cause' defense, the fact that he must wait to do so until proceedings on remand are complete does not make the issue effectively unreviewable."

Miller v. Monumental Life, 2010 U.S. App. LEXIS 8795 at 8; App. at 6-7 (10th Cir. 2010).

This Petition followed.

REASONS FOR GRANTING THE WRIT

The Petition should be granted because the decision creates a clear circuit conflict and allows an insurer to circumvent ERISA protections by asserting a new defense for the first time at the district court level and then claim it is entitled to a remand to the Plan Administrator because the defense has not been developed. The decision of the Tenth Circuit is in conflict with not only its own prior decisions, but with the decisions of numerous other circuits that refuse to permit an ERISA insurer to deny a claim on one basis at the administrative level and assert an additional or new defense to its denial of an ERISA claim during the appeal to the District Court. Rather, prior decisions that allow remand for development of evidence are for cases with a record of the defense already asserted prior to the appeal. This Court should finally resolve this issue, and refuse to allow an ERISA insurer to deny an ERISA claim on one basis at the administrative level and subsequently assert a new defense on appeal to the district court.

As it currently stands, an insurer may wait until federal court litigation is commenced before complying with ERISA requirements that it give notice to a claimant of its reasons for denying a claim and providing a claimant a fair opportunity to dispute the denial at the administrative level. Given this precedent, there is little doubt an insurer's counsel will advise their client that it can have a second chance if during the administrative process it omits a potentially

legitimate defense and saves it for an appeal. This creates an exception to the rule that no new issues may be raised on appeal. Furthermore, it assures that future ERISA claimants will suffer the burdens of additional delays and expenses as a case can now be remanded after a decision on the merits to allow an insurer to assert the untimely-raised defense. Ultimately, it defeats the central purpose of ERISA, which is the speedy and cost-effective resolution of claims.

From the inception of ERISA, it has always been intended that a federal common law of ERISA would be developed to assure consistency in ERISA decisions. The United States Supreme Court first enunciated this view of federal courts' power to create federal common law under ERISA in *Franchise Tax Board v. Construction Laborers Vacation Trust*, 463 U.S. 1 (1983) (superseded on other grounds), based upon the often-repeated assertion upon a statement by Senator Javits, one of ERISA's sponsors, that "[a] body of federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." 120 Cong. Rec. S29942 (statement of Sen. Javits). In addition to consistency of application, ERISA and its accompanying regulations have always been intended to help claimants process their claims efficiently and fairly and were not intended to be used by an insurer as a smoke screen to shield itself from legitimate claims. *Short v. Central States, S.E. & S.W. Areas Pension Fund*, 729 F.2d 567, 575 (8th Cir. 1984). In deciding ERISA cases, the ultimate consideration is "whether

allowance or disallowance of particular relief would best effectuate the underlying purposes of ERISA -- enforcement of strict fiduciary standards of care in the administration of all aspects of pension plans and promotion of the best interests of participants and beneficiaries." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 158, 87 L. Ed. 2d 96, 105 S. Ct. 3085 (1985) (Brennan, J., concurring).

ERISA regulations provide that the plan administrator must provide a claimant with written or electronic notification of an adverse benefits determination in a manner calculated to be understood by a claimant, as follows:

> (i) The specific reason or reasons for the adverse determination;
>
> (ii) Reference to the specific plan provisions on which the determination is based;
>
> (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
>
> (iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a

> civil action under section 502(a) of the Act following an adverse benefit determination on review[.]

See 29 C.F.R. § 2560.503-1(g)(i-iv); *see also* 29 U.S.C. § 1133(1).

The Tenth Circuit has refused to permit an ERISA insurer to assert a new defense at the District Court level. In *Flinders v. Workforce Stabilization Plan of Phillips Petroleum Co.*, 491 F.3d 1180 (10th Cir. 2007), in reviewing a denial of benefits under the more deferential "arbitrary and capricious" standard, the Tenth Circuit explained:

> In reviewing a plan administrator's decision, we may only consider the evidence and arguments that appear in the administrative record. *Sandoval v. Aetna Life and Cas. Ins. Co.*, 967 F.2d 377, 380 (10th Cir. 1992); *see also King v. Hartford Life and Accident Ins. Co.*, 414 F.3d 994, 999 (8th Cir. 2005) ("[A] reviewing court must focus on the evidence available to the plan administrators at the time of their decision and may not admit new evidence or consider post hoc rationales"). This means that, when reviewing a plan administrator's decision to deny benefits, we consider only the

> rationale asserted by the plan administrator in the administrative record ...

Id. at 1190.

The Tenth Circuit further explained, "[t]o determine whether a plan administrator considered and asserted a particular rationale, we look only to those rationales that were specifically articulated in the administrative record as the basis for denying a claim." *Id.* at 1190-91 (citing 29 U.S.C. § 1133(1) (noting that a claim denial must "set[] forth the specific reasons for such denial, written in a manner calculated to be understood by the participant") (emphasis in original). The Tenth Circuit then explained:

> The reason for this rule is apparent – "[w]e will not permit ERISA claimants denied the timely and specific explanation to which the law entitles them to be sandbagged by after-the-fact plan interpretations devised for purposes of litigation." This is consistent with the converse rule that a claimant may not urge new grounds outside the administrative record that would support the award of benefits.

Id. at 1191 (citations omitted).

In sum, the Tenth Circuit in *Flinders* refused to allow the Plan to assert a new defense at the district court level, holding that if it were to allow this, "a plan administrator could simply treat the administrative process as a trial run and offer a post hoc rationale in district court. In addition, such a practice would result in an incomplete administrative record." *Id.*

Given the Tenth Circuit precedent and principles enunciated, it is questionable how the District Court found it could remand for a new issue, and frustrating that the appeals court will not determine the merits of this remand order now and stop the litigation. Rather this issue is eluding review on the merits due to its apparent conflict with another rule on appeal, finality of judgment. Miller urges that this Tenth Circuit holding defeats the rule because it allows litigation of the new issue on appeal to return back to the Plan Administrator, even if there is no basis to allow remand because it is a new issue. The ultimate correct outcome to apply the rule of no new issues on appeal after allowing the new issue and full remand results in a futile and expensive delay as the new litigation should have never occurred.

The Eighth Circuit does not allow ERISA insurers to assert new defenses on appeal from the decision made at the administrative level.[1] In

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[1] In *Hillstrom v. Kenefick*, 484 F.3d 519 (8th Cir. 2007), the Eighth Circuit noted that under *de novo* review of a denial of benefits, a district court "must consider all of the provisions of the policy in question if those provisions are

Marolt v. Alliant Techsystems, 146 F.3d 617, 620 (8th Cir. 1998), the plan administrator did not provide a rationale for its denial of an ERISA claim at the administrative level but presented a basis for the denial for the first time on appeal to the district court. The Eighth Circuit held that the failure to provide a rationale at the administrative level "was contrary to the ERISA statute, federal regulations, and this court's longstanding precedent." *Id.* at 628 (citations omitted). Moreover, in refusing to consider a rationale that was first asserted at the district court level, the Eight Circuit explained that it would not "permit ERISA claimants denied the timely and specific explanation to which the law entitles them to be sandbagged by after-the-fact plan interpretations devised for purposes of litigation" and noted it was "free to ignore ERISA plan interpretations that did not actually furnish the basis for a plan administrator's benefits decision." *Id.* (citation omitted).

The Second Circuit has held that "an [ERISA] insurer is deemed, as a matter of law, to have intended to waive a defense to coverage where other defenses are asserted, and where the insurer possesses sufficient knowledge (actual or

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proffered to the trial court as a reason for denial of coverage, even where not relied upon by the plan administrator at the time the denial was made." *Id.* at 528 (internal quotation marks omitted). However, the Eighth Circuit specifically noted in *Hillstrom* that "after-the-fact interpretations are not at issue here." *Id.* Indeed, the court found, "[n]othing of substance has been advanced in the litigation that was not raised in the administrative process." *Id.* at 527.

constructive) of the circumstances regarding the unasserted defense." *Lauder v. First Unum Life Ins. Co.*, 284 F.3d 375, 382 (2nd Cir. 2002). In *Lauder*, the appeals court explained that the ERISA insurer knew of the claimant's claim of disability, chose not to investigate it, and chose not to challenge it and therefore waived its right to rely on lack of disability as a defense to the claim. *Id.* Furthermore, the appeals court explained that the ERISA insurer was not in the position of having to imagine every conceivable basis for denying the claim; it had all the evidence of disability before it, and could easily have evaluated that evidence to assert a lack of disability defense. *Id.* Moreover, the appeals court explained that:

> [T]his case raises the concern that plan administrators ... will try the easiest and least expensive means of denying a claim while holding in reserve another, perhaps stronger, defense should the first one fail. In light of ERISA's remedial purpose of protecting plan beneficiaries, we are unwilling to endorse manipulative strategies that attempt to take advantage of beneficiaries in this manner...[the ERISA insurer] here chose to proceed on the questionable -- but cheapest -- argument of lack of coverage when it could easily have investigated the merits of [the]

> claim. It should not now get another proverbial bite at the apple.

Id.

Despite this strong pronouncement, the Second Circuit was unwilling to announce a bright line rule to incorporate into the federal common law of ERISA. The court stated:

> Our analysis of the facts presented here leads us to conclude that principles of waiver are appropriately applied in this case. Because we do not consider this the appropriate set of facts on which to create a federal common law doctrine of waiver in the ERISA context, we limit our holding to the circumstances of this particular claim.

Id. at 382.

The Fifth Circuit has found waiver in an ERISA case after "focusing on the unilateral action of the insurer in failing to raise at the outset a known defense to the claim." *Pitts v. American Sec. Life Ins. Co.*, 931 F.2d 351, 357 (5th Cir. 1991). According to the court, "[t]he doctrine of waiver is already an important component of insurance law," using the example that "an insurer automatically waives the terms

of a policy if it defends an insured without a reservation of its rights." *Id.* (citations omitted).

Other circuits have left open the larger question of whether waiver might apply in the ERISA context while concluding that it did not in the specific case. *See Glass v. United of Omaha Life Ins. Co.*, 33 F.3d 1341, 1348 (11th Cir. 1994); *Thomason v. Aetna Life Ins. Co.*, 9 F.3d 645, 650 (7th Cir. 1993). The Fourth Circuit has reached the opposite conclusion, holding that "the federal common law under ERISA . . . does not incorporate the principles of waiver and estoppel." *White v. Provident Life & Accident Ins. Co.*, 114 F.3d 26, 29 (4th Cir. 1997); *see also Crull v. Gem Ins. Co.*, 58 F.3d 1386, 1390-91 (9th Cir. 1995) (holding that state law claims of waiver are preempted under ERISA).

A prime example of the problems faced by federal courts operating without a consistent and uniformly applied rule can be seen in *Winebarger v. Liberty Life Assur. Co.*, 571 F. Supp. 2d 719 (D.W.Va. 2008). Reviewing the denial of benefits under the "arbitrary and capricious" standard, which is by nature much more deferential to the plan administrator's decision as opposed to a *de novo* standard of review, the district court reversed the denial of benefits to a claimant and took issue with the insurer taking "inconsistent positions by encouraging the claimant to seek social security benefits, and then ignoring the finding of the Social Security Administration that the claimant was disabled from any employment." *Id.* at 725 (*citing Metropolitan Life Insurance Co.*

v. Glenn, 554 U.S. 105 (2008)). After explaining the inconsistencies and conflicts of the insurer in denying long term disability benefits, the court reversed the denial of benefits and awarded judgment to the claimant. *Id.* at 726-27. The court further noted that "[w]hile there is no binding precedent in this circuit, there are unpublished opinions holding that only the plan administrator's initial grounds of denial will be considered by the court as justification for withholding benefits, and not any later rationale relied upon in an administrative appeal, in order to prevent beneficiaries from being 'sandbagged by post-hoc justifications of plan decisions.'" *Id.* at 726, fn. 8 (*citing Hall v. Metro. Life Ins. Co.*, 259 F. App'x 589, 593 (4th Cir. 2007) (unpublished) (*quoting Juliano v. Health Maint. Org. of N.J., Inc.*, 221 F.3d 279, 287 (2d Cir. 2000)); *Thompson v. Life Ins. Co. of N. Am.*, 30 F. App'x 160, 164 (4th Cir. 2002) (unpublished).

Several circuits already prohibit supplementation of the record except in when exceptional circumstances are present. In *Hall v. UNUM Life Insurance Co. of America*, 300 F.3d 1197 (10th Cir. 2002), the Court explained "it is the unusual case in which the district court should allow supplementation of the record." *Id.* at 1202. The *Hall* court further explained that "[t]he Court should address why the evidence was not submitted to the Plan Administrator [and] it should only admit the evidence if the party seeking to introduce it can demonstrate that it could not have been submitted to the plan administrator at the time the challenged decision

was made." *Id.* at 1203. The *Hall* court further adopted the standard set in *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1021-27 (4th Cir. 1993) (en banc), which held that to allow supplementation of the record,

> A party seeking to introduce evidence from outside the administrative record bears a significant burden in establishing that he may do so. In particular, (1) the evidence must be "necessary to the district court's de novo review"; (2) the party offering the extra-record evidence must "demonstrate that it could not have been submitted to the plan administrator at the time the challenged decision was made"; (3) the evidence must not be "[c]umulative or repetitive"; nor (4) may it be "evidence that 'is simply better evidence than the claimant mustered for the claim review.'"

Id. at 1203 (*quoting Quesinberry*, 987 F.2d at 1027).

In remanding the case to the Plan Administrator, the District Court has allowed Monumental to assert a new defense raised for the first time by its counsel on appeal, something that is prohibited in every other form of

litigation.[2] ERISA rules already in place contemplate the disallowance of an insurer raising a new defense on appeal to the District Court, just as the rules contemplate denying a claimant the ability to seek a remand to the Plan Administrator to present better evidence. *See id.* Unfortunately, and in contradiction to Congress' purpose that federal courts develop uniformity in ERISA cases, the varied decisions in the circuits has prevented the implementation of a bright-line rule that would prohibit ERISA insurers from denying a claim on one basis at the administrative level and subsequently asserting a new basis for denial during the district court appeal.

What has occurred in this case can be expected to be repeated countless times in the future. Such delays and increased burdens on ERISA claimants result in a Catch-22, where an error is made in ordering remand, but despite the error, the remand must occur before the error of remanding in the first instance can be rectified.

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[2] The District Court's ruling also misapprehends the limited scope of remand by allowing a new defense advanced by Monumental's attorneys for the first time on appeal. Remand is only permitted to allow additional evidence related to or "clarification" of an existing defense. *See e.g. Jewell v. Life Ins. Co. of N. Am.*, 508 F.3d 1303, 1308 (10th Cir. 2007) ("[c]onfining review in general to the administrative record, and thus encouraging the parties to develop the factual record as fully and as early as possible, is important for a variety of reasons related to the goals of ERISA"). The District Court did not cite any exceptional circumstances to explain why it would allow Monumental to assert a new defense on appeal.

Congress certainly did not intend this result in enacting ERISA. Rather, ERISA was designed to ensure the speedy and cost-effective resolution of claims as part of the balance of protecting insureds and providing insurers with protections if ERISA's strict rules are followed. *See e.g. Perry v. Simplicity Engineering*, 900 F.2d 963, 966 (6th Cir. 1990) (court refused to interpret the *de novo* standard of review to allow a district court to consider new evidence, which was not before the fiduciary insurance company, because "such a procedure would frustrate the goal of prompt resolution of claims by the fiduciary under the ERISA scheme").

The issue presented to this Court is whether to hold insurers and Plan Administrators accountable to ERISA's statutes and regulations regarding notice and consideration of disability claims evidence and policy application at the administrative level, or allow new matters after the denial and appeal to the federal court. The Tenth Circuit in this case decided to enforce its own rule citing finality as a reason not to enforce the rule that no new defenses can be raised on appeal. The real effect of the District Court's decision to remand and the Tenth Circuit's refusal to prohibit the assertion of the new defense at this stage is to place the substantial burdens of litigation on claimant Miller while allowing Monumental, who is in a much better position to handle the significant costs and expenses associated with litigation, to turn ERISA litigation into an endurance contest. This is contrary to the central purpose of ERISA,

which has always been intended to streamline the claims process to allow the speedy and efficient determination of claims. Miller is once again forced to go through the administrative process and appeal again, simply because Monumental improperly raised a new defense on appeal. This Court should resolve the conflict in the circuits and provide guidance to the federal courts in enforcing the rule that no new defenses can be raised on appeal, and incorporate the common law concepts of waiver and/or estoppel in ERISA cases in order to further the central purpose of ERISA.

CONCLUSION

For the foregoing reasons, the Petition for Writ of Certiorari should be granted.

Respectfully Submitted,

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JULY 2010

Supreme Court, U.S.
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On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

APPENDIX TO PETITION FOR WRIT OF CERTIORARI

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Court of Appeals Opinion (April 28, 2010) 85

RODNEY MILLER,

Plaintiff,

vs.

MONUMENTAL LIFE INSURANCE COMPANY, et al.

Defendants.

No. CIV 04-0970 JB/RHS

UNITED STATES DISTRICT COURT FOR ΓHE DISTRICT OF NEW MEXICO

2009 U.S. Dist. LEXIS 43859

March 31, 2009, Filed

SUBSEQUENT HISTORY: Appeal dismissed by, Request denied by, Motion denied by Miller v. Monumental Life Ins. Co., 2010 U.S. App. LEXIS 8795 (10th Cir. N.M., Apr. 28, 2010)

PRIOR HISTORY: Miller v. Monumental Life Ins. Co., 502 F.3d 1245, 2007 U.S. App. LEXIS 22741 (10th Cir. N.M., 2007)

COUNSEL: [*1] For Plaintiff: James Rawley, Albuquerque, New Mexico.

For Defendant: Bruce S. McDonald, Lucinda Siembieda, Law Offices of Bruce S. McDonald, Albuquerque, New Mexico; Bernie E. Hauder, Adkerson, Hauder & Bezney P.C., Dallas, Texas.

JUDGES: James O. Browning, UNITED STATES DISTRICT JUDGE.

OPINION BY: James O. Browning

OPINION

MEMORANDUM OPINION AND ORDER

THIS MATTER comes before the Court on: (i) Monumental Life Insurance Company's Supplemental Brief on Sole Cause Issue, filed December 17, 2007 (Doc. 50)("Brief"); (ii) Plaintiff Rodney Miller's Supplemental Memorandum of Law in Support of Motion for Summary Judgment, filed January Brief, filed January 11, 2008 (Doc. 54)("Reply"); and (iv) Plaintiff Rodney Miller's Response to Monumental's 7, 2008 (Doc. 52)("Memo."); (iii) Monumental Life Insurance

Company's Reply and Motion to Strike Plaintiff's Supplemental Motion to Strike, filed January 25, 2008 (Doc. 56)("Response"). The Court held a hearing on February 8, 2008. The primary issues are: (i) whether the Court should find that the accident in question in this case was the sole-cause of Plaintiff Rodney Miller's disability; (ii) whether the Court should strike portions of Miller's brief in which he requests attorney's [*2] fees; (iii) whether, if the Court declines to strike the request for attorney's fees, the Court should award Miller attorney's fees; and (iv) whether the Court should remand the case to the administrator so that a record can be developed on the sole cause issue. While the Court finds that the language in the Policy regarding "sole" and "direct" cause is unambiguous, and imposes the requirements that the disability resulted directly from the work injury and not from any other source, the Court does not believe the record is sufficiently developed for the Court to make a fair determination on the sole-cause issue. The Court will therefore remand the case to the Plan Administrator. The Court will also decline to strike Miller's request for attorney's fees and will not grant attorney's fees at this time.

FACTUAL BACKGROUND

The facts underlying this lawsuit are largely laid out in the Court's Memorandum Opinion and Order, entered June 30, 2005 (Doc. 42)("June 2005 MOO"). In September 1997, Miller was injured in a motor vehicle accident. The primary determination the Court must make at this time

is whether the injuries from the accident were the sole cause of Miller's disability. The Court [*3] will therefore focus on the facts that pertain to that issue.

1. The Policy.

Miller's employer, Aycock Transportation, established a Plan under the Employee Retirement Income Security Act, 29 U.S.C. § 1132 ("ERISA"). See Brief at 1. Monumental Life Insurance Company issued a Master Group Policy to Aycock Transportation, and a Certificate of Insurance under the Master Group Policy to Miller, that provided certain medical, Temporary Total Disability, and Continuous Total Disability ("CTD") benefits. See Reply at 1. The Policy provides that Monumental Life will pay CTD Benefits when: (i) it receives proof that the Insured is Totally Disabled; (ii) the Insured Person has been granted a Social Security Disability ("SSD") Award for such disability; and (iii) the Total Disability "resulted solely and directly from Injury." Master Policy at 10, filed April 29, 2005 (Doc. 28)("Policy"). The Policy defines Total Disability for purposes of the CTD to mean that "the Insured Person is unable to perform every duty pertaining to any occupation for which he is or may become qualified by education, training or experience and has been granted a Social Security Disability Award." Id. at 5. The insurance [*4] is no longer offered. See Reply at 8. Thus, the Policy states that Monumental Life would pay monthly CTD Benefits if the Total Disability "resulted solely and directly from Injury." Policy at 10. The

primary issue in the briefing at this point is whether the Total Disability "resulted solely and directly from the Injury."

It is undisputed that the Plan gave the administrator no discretion and that the Court's review of the denial of benefits is de novo. See Brief at 2. The Court recognized these principles in its order granting Monumental Life's motion for summary judgment, see June 2005 MOO at 13, and the United States Court of Appeals for the Tenth Circuit also recognized these principles in its opinion, see Miller v. Monumental Life Ins., 502 F.3d 1245, 1250 (10th Cir. 2007).

Aycock Transportation was the ERISA plan sponsor, and ERISA required Aycock Transportation, Monumental Life, HCC, or any other entity, to provide Miller with a summary plan description. Miller states that he was not provided with a "summary plan description." Reply at 2 & n.1. There is also no evidence whether Aycock Transportation provided a "summary plan description." Id.

2. Miller's Pre-Accident Condition.

Miller [*5] had some medical conditions that pre-dated the work injury. See Memo. at 13. There is also no evidence in the record when the other conditions arose. See Reply at 2. Nevertheless, those conditions did not prevent him from working as a truck driver. See Memo. at 13. It is undisputed that Miller was physically able to work before the accident of September 15, 1997, and was working as a truck driver. See Memo. at 2. Miller was able to perform all the

truck-driving duties that his employer required before the accident. See id.

It is also undisputed that, on September 15, 1997, while employed by Aycock Transportation and while in the course and scope of his employment with Aycock Transportation, Miller was involved and injured in a motor vehicle accident. See id. The accident caused a back injury. See Memo. at 10. Miller contends that it is further undisputed that, since the motor vehicle accident, Miller became and has been totally disabled, and unable to work and to continue employment. See Memo. at 2. Miller contends that Monumental Life "concedes [he] is totally disabled." Memo. at 2. Monumental Life contends that it has not conceded or admitted that Miller is totally disabled. See Reply [*6] at 1.

Miller admits that he became disabled "due to the combined effects of chronic back pain associated with facet arthropathy with cervical and lumbar radiculopathy, carpal tunnel syndrome, bi-polar affective disorder and valvular heart disease with valve replacement." Defendants' Notice of Removal, Complaint for ERISA Plan Benefits P 8, at 6, filed August 27, 2004 (Doc. 1)("Complaint").

3. The SSA's Findings.

Miller applied for SSD and for Supplemental Security Income ("SSI") benefits. See Brief at 2. The Social Security Administration ("SSA") denied Miller's request for SSD benefits, but found that he met the requirements for SSI benefits, found that he was entitled to those

benefits up through at least June 1, 2005, and approved his request for SSI benefits. See Exhibit 5 to Motion for Summary Judgment, Notice of Decision - Favorable at 1, dated March 1, 2001 ("SSI Decision")(granting SSI benefits); Exhibit 4 to Motion for Summary Judgment, Notice of Decision - Unfavorable at 1, dated August 28, 2003 (denying Miller SSD benefits). The SSA paid Miller a "Supplemental Security Income Award." SSI Decision at 1.

In the decision on Miller's request for SSI benefits, the SSA framed the [*7] general issue the Administrative Law Judge ("ALJ") was to determine as:

> [W]hether the claimant is disabled under Section 1614(a)(3)(A) of the Social Security Act. The specific issue is whether he is under a disability, which is defined as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months.

SSI Decision at 1. The ALJ determined that "the medical evidence establishes that claimant has the following severe impairments: chronic neck and back pain associated with facet arthropathy with cervical and lumbar radiculopathy, carpel tunnel syndrome, bipolar affective disorder and

valvular heart disease with valve replacement." SSI Decision at 3. Although the ALJ found that none of these impairments met the criteria of any listed impairment, the ALJ concluded that, because Miller was unable to perform the physical and mental requirements of any past relevant work, because Miller had no transferrable skills to work he could perform, and because Miller could not make an adjustment to any [*8] work that exists in significant numbers in the national economy, Miller was disabled within the framework of medical-vocational rule 201.00(h). SSI Decision at 3. The ALJ also found that Miller was under a disability, as defined in the Social Security Act, which continued for a sufficient period of time to qualify for the SSI benefit. See id. at 4. Accordingly, Miller received a monthly SSI Award from May 1, 2001 through June 1, 2005. See Brief at 2.

4. The Administrative Record.

Miller submitted a claim for CTD benefits under the Policy. See Brief at 2. It is undisputed that Miller's claim was the first and only claim the Plan Administrator or Monumental Life ever faced where an insured received an SSI Award and sought Continuous Disability Benefits ("CDB") under the policy. See Reply at 8. Monumental Life was not the Plan Administrator or third-party administrator. See Reply at 4 n.2. Monumental Life did not administer or make the decisions on Miller's claim for benefits under the Policy. See id.

In the letter setting forth her decision to deny Miller CTD benefits, the Plan Administrator did

not mention sole cause, and she gave no inclination regarding whether Miller was Totally Disabled, [*9] as defined in the Policy. See Letter from Madelynn Collins to Rodney Miller at 1, dated November 19, 2003 ("Plan Administrator's Letter"). In its entirety, the body of the letter states:

> Based on a review of your policy terms it does not appear that you are eligible for continuous total disability.
>
> According to the terms of the policy in order to be eligible for continuous total disability you must be unable to engage in any gainful employment for which you can be reasonably trained for [sic].
>
> You must be awarded a social security disability award for injuries sustained from this accident of 9-15-97. The information you have provided to us from the social security office is for supplemental security income and not a social security disability award. Therefore, no benefits are available.

Plan Administrator's Letter at 1. Thus, the Plan Administrator denied the claim on one basis: that Miller did not receive a social security disability award. See id.

Monumental Life contends that Miller admits the administrative record included the SSA decision on Miller's request for SSD and SSI

benefits. See Reply at 2. When the Plan Administrator denied Miller's claim, she was in possession of the entire [*10] decision of the Social Security ALJ regarding Miller's Social Security Disability Award. See Memo. at 6. The evidence presented to and before the Plan Administrator included Miller's medical records, and the findings of the SSA as set forth in its decisions on Miller's request for SSD and SSI benefits. See Brief at 2. The Policy was also before the Plan Administrator. See Brief at 2. Miller never alleged, and presented no evidence, that he was Totally Disabled, as defined in the Policy, or that any such Total Disability "resulted solely and directly from Injury." Reply at 2.

Miller asserts that Monumental Life did not argue that Miller's Total Disability did not result solely and directly from the injury at the administrative level. See Memo. at 4. Miller argues that the first time that Monumental Life raised this issue was in its initial motion for summary judgment. See id.

Miller contends that, after he applied for CTD benefits, Monumental Life denied his claim based on its position that Miller did not receive a "Social Security Disability Award." Memo. at 5. As Miller had not, in the opinion of the Plan Administrator, received a "Social Security Disability Award," as the Policy ostensibly [*11] states, and as the Plan Administrator read the Policy to require, the Plan Administrator denied Miller's claim for CTD benefits, finding that Miller had not received a SSD Award. See Brief at 2. Miller contends that it is without dispute that Monumental Life at no

time based its decision to deny Miller CDB based on the Policy exclusion that a total disability "resulted solely and directly from the Injury." Memo. at 5. Miller argues that the decision to deny Miller benefits was based on what was an erroneous application of the term "Social Security Disability Award." Id. Miller asserts that the Plan Administrator based the denial solely on her contention that what Miller presented to her was not a Social Security Disability Award. See id. In its Supplemental Brief on the Sole Cause issue, in the section headed "Summary of Facts," Monumental Life admits that the only reason that Miller was denied CDB was that Miller had not received a "Social Security Disability Award." Brief at 2 ("As Miller had not received a 'Social Security Disability Award' as the Policy states and as the Plan [A]dministrator read the Policy to require, the Plan [A]dministrator denied Miller's claim for CTD benefits [*12] finding Miller had not received a Social Security Disability Award."). Thus, it is undisputed that the denial was based on its Plan Administrator's position that Miller did not receive a "Social Security Disability Award." As the Tenth Circuit made clear in its decision, as a matter of law, Monumental Life's denial on this basis was erroneous. See Miller v. Monumental Life Ins., 502 F.3d at 1252.

5. The Plan Administrator.

Miller contends that information about the onset of disability, medical evidence, accident reports, and employment history was not made part of the administrative record. See Memo. at 6. Miller asserts that the only document identified

as the administrative record is the denial letter, which references the Social Security Disability award issue. See Memo. at 4. Monumental Life contends that "[t]he evidence presented to and before the Plan [A]dministrator included Miller's medical records and the findings of the SSA as set forth in its decisions on Miller's request for SSD and SSI benefits." Brief at 2. Monumental Life argues that "[t]his Court's de novo review can and should include consideration of the evidence before the Plan [A]dministrator [*13] and terms of the Policy." Id. at 3. Miller admits that he became disabled "due to the combined effects" of these impairments. Complaint P 8, at 6.

A possible ground for denying Miller's claim for Policy benefits was Miller's disability did not result "solely and directly" from accidental bodily injury sustained "solely through external, violent and accidental means and independently of all other causes," and did not arise "solely out of or in the course of his usual and customary duties of his regular occupation." Brief at 2. Monumental Life maintains that the evidence to support this reason for denial was before the Plan Administrator at the time it made the decision on Miller's claim for Policy benefits. See id. at 2-3. Miller contends that information regarding the onset of his disability, his medical evidence, the accident reports, and his employment history were not made part of the administrative record, because the Plan Administrator did not rely on this information to find that Miller failed to establish sole cause, as the Policy requires. See Memo. at 6 (citing Buzzard v. Holland, 367 F.3d 263, 270-71 (4th Cir. 2004)(reversing trustees'

decision to deny benefits for their failure [*14] to consider claimant's SSDI award and its evidence that work exacerbated pre-accident medical conditions)).

PROCEDURAL BACKGROUND

Miller filed this suit on July 16, 2004, in the Second Judicial District, Bernalillo County, New Mexico. See Complaint at 1. Miller's action is for group welfare benefits under ERISA. The only claim that Miller asserts is for the breach of contract. Miller and his counsel have a standard forty-percent fee plus tax fee agreement. See Memo. at 16. Miller requested attorney's fees in his Complaint. See Complaint at 7.

1. Proceedings in the District Court.

Miller requested attorney's fees in his motion for summary judgment. See Motion for Summary Judgment at 2, filed April 29, 2005 (Doc. 27)("Motion for Summary Judgment"). Nevertheless, Monumental Life contends that Miller never raised any issue in the summary judgment proceeding of his entitlement to attorney's fees. See Reply at 5. Monumental Life asserts that Miller did not raise the issue in his Motion for Summary Judgment nor in his responses to Monumental Life's Motion for Summary Judgment. See id. Monumental Life contends that no evidence was produced regarding attorney's fees, and they were never raised [*15] or addressed before Miller addressed them in his memorandum on the sole cause issue. See id.

The Court determined Miller's "Supplemental Security Income Award" was not a "Social Security Disability Award" and thus no CTD Benefits were owing under the Policy. See Miller v. Monumental Life Ins., 502 F.3d at 1248 (noting that the Court "granted Monumental's motion for summary judgment on the theory that the Plan unambiguously provided that a Title XVI award was not a Social Security Disability Award."). In his motion for summary judgment, Miller suggested "he is entitled to Continuous Total Disability Benefits under the Policy because of his SSI award." June 2005 at 18.

> [S]uch benefit would be reduced 100% by his SSI award and, as a result of any such payment of Continuous Total Disability, his SSI Award would cease. Once the SSI award ceases, Miller would lose entitlement to Continuous Total Disability Benefits as those benefits end when his "Social Security Disability Award ceases." Policy at 10. Miller's construction is unreasonable and leads to an absurd and unintended result.

June 2005 MOO at 18.

2. The Tenth Circuit.

The Tenth Circuit applies federal common law in ERISA cases. See Miller v. Monumental Life Ins. Co., 502 F.3d at 1249. [*16] The Tenth Circuit held Miller could have "reasonably

expected" that his receipt of a "Supplemental Security Income Award" was sufficient to satisfy the Policy requirement of a "Social Security Disability Award" and entitled him to the initial receipt of the monthly benefit. Id. at 1251. The Tenth Circuit did not address the result that occurs from such an interpretation.

On appeal, the Tenth Circuit noted that, "[i]n interpreting an ERISA plan, [it] examine[s] the plan documents as a whole and, if ambiguous, construe[s] them as a matter of law." 502 F.3d at 1250 (internal quotations omitted). The Tenth Circuit held that the ERISA plan at issue is ambiguous. See 502 F.3d at 1250. The Tenth Circuit decided that "[a]n examination of the programs' respective regulations strengthened [its] conclusion that a reasonable plan participant could reasonably believe that either a Title II or a Title XVI award was a Social Security Disability Award." 502 F.3d at 1251. "In contrast[, however,] to the Title XVI Decision, the ALJ's findings in the Title II proceeding bore no relation to . . . Miller's ability to engage in productive labor." 502 F.3d at 1251. Thus, "to be eligible for Title II benefits, [*17] an individual must be both insured for disability benefits and disabled within the meaning of the Act." 502 F.3d at 1251. "Hence, [the Tenth Circuit held] that the Plan is ambiguous because the term Social Security Award is reasonably susceptible to more than one meaning." Id. at 1253 (internal quotations omitted).

The Tenth Circuit held that Monumental Life delegated the substantive disability

determination to the SSA. See id. at 1250. The Tenth Circuit noted: "The Plan mandates that a beneficiary be incapable of engaging in productive labor. However, it provides no mechanism for assessing his physical condition, other than whether he has received a Social Security Disability Award." Id. at 1250-51. Thus, "Monumental [Life]'s delegation suggests that a reasonable person could have expected Mr. Miller's Title XVI award and the SSA's finding of disability to have satisfied the Social Security Award requirement." Id. at 1251. The SSA's conclusion that Miller "was unable to perform every duty pertaining to any occupation for which he is or may become qualified by education training or experience . . . seems to satisfy the Plan's requirement that a recipient of Continuous Benefit be unable [*18] to perform the physical and mental requirements of any past relevant work." Id. (internal quotations omitted).

The Tenth Circuit then applied the doctrine of contra proferentem which "construes all ambiguities against the drafter." Id. It noted that it has "rejected contra proferentem in cases where the [P]lan [A]dministrator retains discretion and where [it] review[s] only to consider whether the administrator abused discretion." Id. (citing Kimber v. Thiokol Corp., 196 F.3d 1092, 1100 (10th Cir. 1999)). The Tenth Circuit nevertheless applied the doctrine in "reviewing an ambiguous ERISA plan de novo." Miller v. Monumental Life Ins. Co., 502 F.3d at 1253. The Tenth Circuit "construe[d] the Plan's terms in favor of Mr. Miller and held that his Title XVI award coupled with a finding of disability satisfied the Social

Security Disability Award requirement." Id. at 1255.

The Tenth Circuit remanded the case to the Court to address the issue whether Miller's work-related injury was the "sole cause" of his disability. Miller v. Monumental Life Ins. Co., 502 F.3d at 1255. The Tenth Circuit explained: "We note that Monumental [Life] also moved for summary judgment on the grounds that Mr. Miller's [*19] accident was not the 'sole cause' of his disability. . . . Because the district court did not address this issue, we must remand for further proceedings." Id. The Court allowed the parties to provide supplemental briefing on this issue, directing

> the parties to rebrief the issue related to the "sole cause" of Plaintiff Rodney Miller's disability. Alternatively, the parties may rely on their prior briefing by submitting their prior briefs highlighted to show precisely what the Court should consider and resolve. The parties should respond to this order within 10 days of the date of the order.

Monumental Life submitted additional briefing only on the issue whether the Court can consider the "sole cause" argument. See Brief at 1. On December 17, 2007, Monumental Life filed its Supplemental Brief on the issue of sole cause. See id. In its Background portion, Monumental

Life again argues that it is entitled to summary judgment, this time on sole cause. See id. Monumental Life relies upon the facts and its Briefs filed herein on its Motion for Summary Judgment on the issue of "sole cause." Id. For the reasons set forth in its Supplemental Brief and in its earlier briefing, Monumental Life maintains [*20] that it is entitled to summary judgment on Miller's claim for benefits under the Policy. See id.

On January 7, 2008, Miller submitted, pursuant to rule 56(b), his Supplemental Memorandum of Law in Support of his Motion for Summary Judgment. See Memo. at 1. Miller incorporates the original Motion for Summary Judgment as if fully set out in his Supplemental Memorandum. See id. In addition, Miller offers his Supplemental Memorandum in light of the Tenth Circuit's decision on appeal. See id. Miller, by the motion for summary judgment, responds to Monumental Life's Supplemental Motion on sole cause. See id.

In its Reply and Motion to Strike, Monumental Life argues that the Court should strike that portion of Miller's Supplemental Memorandum discussing attorney's fees and deny his request for attorneys' fees. See Reply at 9.

At the February 8, 2008 hearing, Miller contended that the Tenth Circuit does not favor remand to Plan Administrators as a remedy. See Transcript of Hearing at 14:13-15:9 (taken February 8, 2008)(Court & Rawley)("Tr."). Miller asserted that Hall v. UNUM Life Insurance Co. of America, 300 F.3d 1197 (10th Cir. 2002), supports

his contention that the Tenth Circuit disfavors [*21] remand as a remedy. See Tr. at 14:22-24 (Court & Rawley). Miller argued that a finding of disability by the SSA is a finding of total disability. See id. at 16:24-17:1 (Rawley). Miller contended that the burden is on Monumental Life to inform him of the basis for its denial of benefits to him. See id. at 20:19-21:5 (Rawley). Miller also asserts that the "sole cause" language is not a policy exclusion. Id. at 21:7-10 (Rawley). Miller described the Plan Administrator's review as follows:

> THE COURT: How is it normally done? Does the plan administrator say, give two or three reasons as to why they're denying the policy, that tips the beneficiary off that those are the things in issue and then there's a motion to reconsider or an appeal and that's when you bring in the evidence?
>
> MR. RAWLEY: It's not that difficult or legalistic. The administrator would send a letter saying it looks as though you failed to meet this requirement. We'll need to have additional evidence or we'll have to deny you at this time. I see those sorts of letters all the time. Frequently they're saying we can't decide this yet because you don't have an opinion from this doctor and we sent out disability statement to a [*22] doctor, things like that. So all the time you're going back and forth making sure that

> they get what they need in order to have the medical evidence in the record or you're telling them we're waiting for the Social Security decision we'll send that to you. So there is communication about genuine issues. But it doesn't and then when there's a final denial, even then you can if they said they'll usually say but if you have additional medical record you know or something to change our opinion you know you can then appeal it. There's a lot of mechanisms. You can come in later, too, if you have new evidence. I mean, the whole idea is that they're going to give you your disability if you show them you're entitled it's just a matter of getting your ducks in a row or getting your evidence in front of them.

Id. at 23:3-24:3 (Court & Rawley). Miller represented that he did not raise the attorney's fees issue earlier because it was too early to think he had prevailed. See id. 24:18-19 (Rawley). Miller clarified that "[c]ertainly all I'm asking for is if we prevail that the Court would then allow us to submit the evidence concerning the hours and the times and all of that." Id. at 25:1-3 (Rawley). [*23] Miller acknowledged that "it's a legal question as to whether [the Court finds] that we meet the factors under Gordon v. United States Steel Corp., 724 F.2d 106, 108 (10th Cir. 1983)." Tr. at 25:3-5 (Rawley). Miller conceded

that, were Monumental Life to pay him long-term disability benefits, then his Title 16 benefits would cease. See id. at 27:7-10 (Court & Rawley). Miller asserts that he has met his summary-judgment burden with the evidence accepted by the SSA's decision regarding onset of his disability and the determination of total disability from the date of onset in the SSA's decision. See id. at 73:7-11 (Rawley). Miller contends that he met the burden of proof at the administrative level when he presented the administrator with his medical records to prove Miller was disabled. See id. at 74:11-13 (Rawley). Miller does not believe that supplementation of the record is appropriate. See id. at 74:25-75:1-6 (Court & Rawley). Miller contends that Monumental Life has stated that the Plan Administrator had access to the findings of the SSA when making the decision. See id. at 75:15-18 (Court & Rawley).

> 1 The Court's citations to the transcript of the hearing refer to the Court Reporter's [*24] original, unedited version. Any final transcript may contain slightly different page and/or line numbers.

Monumental Life contended that "[i]t doesn't matter what the [Plan] [A]dministrator said, period. You're reviewing it de novo . . . you don't have to worry about giving any type of weight or anything to the evidence." Id. at 36:4-7 (Hauder). Monumental Life asserted that it thinks "on de novo review . . . the Court is allowed to consider this additional ["sole cause"] argument." Id. at 37:14-16 (Hauder). Monumental Life argued that

the "sole cause requirement" is separate from the requirement that Miller be "totally disabled." Id. at 39:1-4 (Hauder). Monumental Life conceded that the Court is stuck with the SSA's determination of the cause of the disability, including the SSA's determination that the work-related injury included the previous impairments. See id. at 42:21-43:2 (Court & Hauder).

> MR. HAUDER: . . . How can we say not say that's what the . . . cause of disability.
>
> THE COURT: I think we're all stuck with that right.
>
> MR. HAUDER: What the cause of the disability is.
>
> THE COURT: Right.
>
> MR. HAUDER: So if all of these things are the cause of the disability then how can the work [*25] relate injury be the sole cause if valvular heart disease wasn't . . . a part of the work-related injury.
>
> THE COURT: How do I know that? From this reward? I mean I'm not a doctor. How do I know that the accident didn't cause the [heart] problem? [Is there a way] in the record to disconnect those? . . .
>
> MR. HAUDER: You're right.
>
> THE COURT: It's almost silent. It it doesn't it doesn't tell me anything

> about what his prior condition was, what the cause of.
>
> MR. HAUDER: So then the proper thing for[] the Court to do is deny the motion for the sole cause issue and have the parties present evidence of that. Because what you're saying is there's not enough evidence there's not enough evidence for me to move or for you to grant the sole cause issue and that issue is still there before the Court. . . . [B]ut I'm also concern that there's not evidence to grant it for the plaintiff. The record is almost silent on the sole cause.

Id. Monumental Life represented that it had found only Hillstrom v. Kenefick, 484 F.3d 519 (8th Cir. 2007), and Hall v. UNUM Life Insurance Co. of America, 300 F.3d 1197 (10th Cir. 2002), as guidance for whether the Court can address an issue that was not decided by the Plan [*26] Administrator and whether the Court may address the administrative record relied upon by the Plan Administrator. See Tr. at 46:15-19 (Hauder). Monumental Life contended that the phrase "sole cause" is not ambiguous in its Policy. See id. at 60:12-13 (Hauder). Monumental Life asserted that the Court should retain the case and decide it, because if the Plan Administrator decides the issue, then its decision will be relitigated in federal court by Monumental Life if the decision is in favor of Miller. See id. at 61:3-7 (Hauder). Monumental Life argues that the "sole

cause" language in the Policy is not an exclusion. See id. at 61:24-25 (Hauder). Monumental Life asserted that Miller has the burden of proof to show he is entitled to the benefits he claims under the Policy. See id. at 62:8-12 (Hauder). Monumental Life asserted that, "out of fairness . . .

> maybe the thing to do is allow a supplementation of the record" considering that Miller did not have any notice that the "sole cause" language in the Policy was going to be an issue, and considering that there is no record whether the Plan Administrator relied on that language to deny benefits. Id. at 62:19-63:9 (Court & Hauder). Monumental [*27] Life conceded that "[t]here's no doubt the [Plan] administrator didn't get to [the sole cause] issue." Id. at 64:9-11 (Hauder). Monumental Life admitted that the SSA found Miller disabled, but would not admit that he was totally disabled the way that "totally disabled" is defined under the Policy. Id. at 65:15-18 (Hauder). [2]

2 Monumental Life asserts that it has obtained surveillance video that undermines Miller's contention that he is, or ever has been, Totally Disabled. See Monumental's Motion to Remand and Brief P 9, at 4, filed March 2, 2009 (Doc. 62).

LAW REGARDING DE NOVO REVIEW OF AN ERISA PLAN ADMINISTRATOR'S DECISION

ERISA's goal is "uniform national treatment of pension benefits." Patterson v. Shumate, 504 U.S. 753, 765, 112 S. Ct. 2242, 119 L. Ed. 2d 519

(1992). Under ERISA, Congress has authorized the courts "to formulate a nationally uniform federal common law to supplement the explicit provisions and general policies set out in [the Act]." Peterson v. Am. Life & Health Ins. Co., 48 F.3d 404, 411 (9th Cir. 1995). The Tenth Circuit applies the federal common law in ERISA cases in recognition of the Congressional intent that ERISA plans are administered See Miller v. Monumental Life Ins. Co., 502 F.3d at 1249.

1. [*28] **Burden of Proof**.

The burden is on an insurance beneficiary to prove his or her total disability benefits under an ERISA plan. See Morales-Alejandro v. Medical Card System, Inc., 486 F.3d 693, 700 (1st Cir. 2007)("A claimant seeking disability benefits bears the burden of providing evidence that he is disabled within the plan's definition."); Fuja v. Benefit Trust Life Ins. Co., 18 F.3d 1405, 1408 (7th Cir. 1994)("The trial court determined that because the 'medically necessary' provision of the insurance contract is set forth in the contract benefits section, as opposed to the 'exclusions' section, that Fuja bore the burden of establishing her entitlement to the insurance benefits. We agree with the trial court's determination on this issue."); Gable v. Sweetheart Cup Co.., 35 F.3d 851, 855 (4th Cir. 1994)("Moreover, plaintiffs bear the burden of proving that their employer's ERISA plan contains a promise to provide vested benefits."); Horton v. Reliance Standard Life Ins. Co., 141 F.3d 1038, 1040 (11th Cir. 1998)(holding that a plaintiff suing under a section allowing a beneficiary to bring a civil action to recover

benefits due to him under the terms of his plan, to enforce his [*29] rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan bears the burden of proving his entitlement to contractual benefits, but noting that, if the insurer claims that a specific policy exclusion applies to deny the insured benefits, the insurer generally must prove the exclusion prevents coverage); Farley v. Benefit Trust Life Ins. Co., 979 F.2d 653, 658 (8th Cir. 1992)(agreeing that it was the beneficiary's burden to show that he was entitled to the benefits under the terms of his plan)(citing 29 U.S.C. § 1132(a)(1)(B)).

2. De Novo Review.

A de novo review is restricted to the administrative record. As the Tenth Circuit explained in Hall v. UNUM Life Insurance Co. of America:

> [T]he best way to implement ERISA's purposes in this context is ordinarily to restrict de novo review to the administrative record, but to allow the district court to supplement that record when circumstances clearly establish that additional evidence is necessary to conduct an adequate de novo review of the benefit decision.

300 F.3d at 1202 (internal quotations omitted). The Tenth Circuit further "emphasize[d] that it is the unusual case in which the district [*30] court

should allow supplementation of the record." Id. at 1203 (citing Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d 1017, 1025 (4th Cir. 1993)(en banc)("In most cases, where additional evidence is not necessary for adequate review of the benefits decision, the district court should only look at the evidence that was before the [P]lan [A]dministrator or trustee at the time of the determination.")). The Tenth Circuit in Hall v. UNUM Life Insurance Co. listed exceptional circumstances that may warrant the admission of additional evidence: (i) claims that require consideration of complex medical questions or issues regarding the credibility of medical experts; (ii) the availability of very limited administrative-review procedures with little or no evidentiary record; (iii) the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts; (iv) instances where the payor and the administrator are the same entity and the court is concerned about impartiality; (v) claims that would have been insurance contract claims before ERISA; and (vi) circumstances in which there is additional evidence that the claimant could not have presented in the [*31] administrative process. See 300 F.3d at 1203.

In Hall v. UNUM Life Insurance Co., the insurance company's principal argument on appeal was that "the district court improperly considered evidence outside of the administrative record relied upon by [the insurance company] when it terminated [the plaintiff]'s benefits." Id. at 1199. The plaintiff worked as a regional vice president and was a participant in her employer's

group long-term disability-insurance plan. See id. Under that plan, she was entitled to benefits if she was disabled and "unable to perform the material duties of [her] regular occupation." Id. (internal quotations omitted). The plaintiff injured her shoulder in a bicycle accident. See id. The insurance company concluded that the plaintiff was disabled and approved the payment of long-term disability benefits to her. See id. Approximately a year later, an insurance company employee investigated whether the plaintiff remained disabled. See id. The insurance company determined that the plaintiff was no longer disabled "because the restrictions on her physical activities did not prevent her from undertaking work as a vice-president of sales." Id. The reevaluation included [*32] "surreptitious video surveillance of" the plaintiff. Id. The plaintiff sought additional medical treatment because of continuing pain in her shoulder. See id. at 1200. The plaintiff informed the insurance company of the additional treatment, when she sought to have her termination of disability payments reconsidered, but the insurance company was not informed of additional surgeries that the plaintiff underwent. See id. The plaintiff filed suit against the insurance company, contending that the insurance company had violated ERISA by improperly terminating her disability benefits. See id. The district court found that the insurance company breached its duty to the plaintiff under ERISA, and ordered the insurance company to pay pre-judgment interest and attorney's fees to the plaintiff. See id. The insurance company appealed, arguing that the

district court erred in allowing admission of evidence outside of the administrative record and awarding the plaintiff attorney fees. See id.

The Tenth Circuit explained in Hall v. UNUM Life Insurance Co. that the Tenth Circuit agreed "that the best way to implement ERISA's purposes . . . is ordinarily to restrict de novo review to the administrative [*33] record, but to allow the district court to supplement that record when circumstances clearly establish that additional evidence is necessary to conduct an adequate de novo review of the benefit decision." Id. at 1202. The Tenth Circuit was concerned that, "[u]nless [it] allow[s] employees the possibility of supplementing the record in such circumstances, [it] run[s] the risk of providing employees fewer procedural rights than they had prior to the enactment of ERISA." Id. The Tenth Circuit noted that a "variety of ERISA cases . . . are brought to the federal courts." Id. (internal quotations omitted). The Tenth Circuit explained:

> Some of these cases reach the courts with substantial administrative records because of the [P]lan [A]dministrator's detailed procedures and record-keeping for benefit determination decisions. Other cases arrive with very limited records. . . . ERISA cases also may involve plans in which the payor and administrator are one and the same, or different entities, and they may involve complex issues of medicine, law, and plan interpretation. . . . Given this diversity, providing the

> district courts with flexibility to admit additional evidence in limited circumstances [*34] is appropriate and even necessary in order to address the varied situations in which the administrative record alone may be insufficient to provide proper de novo review.
>
> We emphasize that it is the unusual case in which the district court should allow supplementation of the record. . . . In most cases, where additional evidence is not necessary for adequate review of the benefits decision, the district court should only look at the evidence that was before the plan administrator or trustee at the time of the determination. . . . The party seeking to supplement the record bears the burden of establishing why the district court should exercise its discretion to admit particular evidence by showing how that evidence is necessary to the district court's de novo review.

Id. at 1202-03 (internal citations and quotations omitted). In considering a motion to supplement the record, the court should "address why the evidence was not submitted to the [P]lan [A]dministrator . . . and should only admit the additional evidence if the party seeking to introduce it can demonstrate that it could not have been submitted to the plan administrator at

the time the challenged decision was made." Id. at 1203 [*35] (internal quotations omitted). On the other hand, if the Plan Administrator did not allow for or permit the introduction of the new evidence, then "its admission may be warranted." Id.

3. Coverage Cannot be Created by Waiver or Estoppel.

Principles of waiver and estoppel cannot be used to modify the express terms of an ERISA plan. See Miller v. Coastal Corp., 978 F.2d 622 (10th Cir. 1993)(stating that "ERISA's express requirement that the written terms of a benefit plan shall govern forecloses the argument that Congress intended for ERISA to incorporate state law notions of promissory estoppel."); Bakery v. Confectionary Union & Indus. Int'l Pension Fund v. Ralph's Grocery Co., 118 F.3d 1018, 1027 (4th Cir. 1997)(stating that, "[i]n this circuit, equitable estoppel is not available to modify the written terms of an ERISA plan in the context of a participant's suit for benefits."); Mullins v. Blue Cross and Blue Shield of Va., Inc., 79 F.3d 380, 381 (4th Cir. 1996)(noting "[e]quitable estoppel ... [has] not been permitted to vary the written terms of a plan.")(internal quotations omitted). This rule is based on ERISA's exacting requirement that the express terms of the ERISA benefit plan [*36] be followed.

In Hillstrom v. Kenefick, 484 F.3d 519 (8th Cir. 2007), the United States Court of Appeals for the Eighth Circuit held that, on de novo review of a denial of benefits under an ERISA plan, "'a trial court must consider all of the provisions of the

policy in question if these provisions are proffered to the trial court as a reason for denial of coverage,' even where [such provisions were] . . . 'not relied upon by the [P]lan [A]dministrator at the time the denial was made.'" 484 F.3d at 528 (quoting Weber v. St. Louis Univ., 6 F.3d 558, 560 (8th Cir. 1993)). The Eighth Circuit in Hillstrom v. Kenefick stated: "To do otherwise would permit the oral modification of employee welfare plans governed by ERISA, a result manifestly in conflict with the intent of the statute and with the case law governing it." 484 F.3d at 528 (internal quotations omitted). The Eighth Circuit, in Hillstrom v. Kenefick, noted that "de novo review on an expanded record would produce the same conclusion as de novo review of the administrative record alone." Hillstrom v. Kenefick, 484 F.3d at 528 (citing Conley v. Pitney Bowes, 176 F.3d 1044, 1049 (8th Cir. 1999), cert. denied, 528 U.S. 1136, 120 S. Ct. 979, 145 L. Ed. 2d 930 (2000)).

The [*37] plaintiff in Hillstrom v. Kenefick contended that the insurance company denied his benefits because he was not a "Salaried Employee" under the policy, and because the "Salaried Employee" language was "merely a boilerplate or orphan definition in the policy, and [wa]s not found in the substantive terms of the policy, [the plaintiff] conten[ded] that he was not required to be a Salaried Employee in order to be covered by the policy." 484 F.3d at 527 (internal quotations omitted). The Eighth Circuit reasoned that "the record reflects that by no means did [the Plan Administrator] rely on that explanation alone." Id. The Eighth Circuit explained:

"Numerous times over the months that [the plaintiff]'s claim was pending, [Plan Administrator] employees corresponded with [the plaintiff's attorney], seeking additional information under the specified terms of the policy. Policy definitions were set out, and areas where evidence was lacking were identified." Id. at 527. The Eighth Circuit thus "reject[ed] the contention that [the insurance company] [wa]s now advancing post hoc rationales for denying benefits." Id. [*38] (internal quotations omitted). The Eighth Circuit rejected that contention, because

> the letters from [the Plan Administrator] consistently iterated that [the plaintiff] had not shown that he was eligible to receive benefits, had not shown that he was disabled, and had not shown proof of loss as defined by the policy. Some of those letters requested specific information to verify the source of [the plaintiff]'s income; the amount of earnings received from [the employer], if any; [the plaintiff]'s duties for [the employer]; and the nature and onset of his disability. Nothing of substance has been advanced in the litigation that was not raised in the administrative process. It may be true that [the insurance company] devotes far more diligence in this litigation to challenging the existence, nature, and onset of [the plaintiff]'s asserted disability than [the

> Plan Administrator] did in its administrative denials. There is even some indication in the record that the insurer may have acquiesced to the fact of disability, at least on some level. But ineligibility on this basis was mentioned in the denial letters.

Id. at 527-28. Thus, the Eighth Circuit decided that, even if the insurance company [*39] "were relying on new rationales that were not part of the administrative record," the plaintiff's claim would fail, because all the rationales, except for the Salaried Employee definition, were based on specific policy requirements. Id. at 528.

The Tenth Circuit in Jewell v. Life Ins. Co. of North America, 508 F.3d 1303 (10th Cir. 2007), recently confirmed that, in a district court's review of an ERISA Plan Administrator's decision, a party seeking to introduce evidence from outside the administrative record must establish the four elements that the Tenth Circuit set out in Hall v. Union Life Insurance Co. of America, 300 F.3d at 1202. See Jewell v. Life Ins. Co. of North America, 508 F.3d at 1309. The Tenth Circuit explained: "The best way for a district court to implement ERISA's purposes in this context is ordinarily to restrict de novo review to the administrative record compiled during the claim administration process, instead of taking new evidence, hearing witnesses, and the like." Id. (internal quotations omitted).

> A party seeking to introduce evidence from outside the administrative record bears a significant burden in establishing that he may do so. In particular, [(i)] the [*40] evidence must be "necessary to the district court's de novo review;" [(ii)] the party offering the extra-record evidence must "demonstrate that it could not have been submitted to the [P]lan [A]dministrator at the time the challenged decision was made;" [(iii)] the evidence must not be "[c]umulative or repetitive;" nor [(iv)] may it be "evidence that 'is simply better evidence than the claimant mustered for the claim review.' "

Id. (quoting Hall v. Union Life Ins. Co. of Am., 300 F.3d at 1203 (quoting in turn Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d at 1027))(internal quotation marks omitted). The Tenth Circuit reiterated that the "exceptional circumstances" listed in Hall v. Union Life Insurance Co. of America "are not exceptions to the Hall rule; they are merely examples of circumstances that might militate in favor of a finding of necessity." Jewell v. Life Ins. Co. of N. Am., 508 F.3d at 1309. Thus, "[t]he existence of one or more of these circumstances does not make extra-record evidence automatically admissible, for if it did, then supplementation of the record would not be limited to unusual cases or extraordinary circumstances." Id. "District courts

must conduct analysis [*41] case-by-case to determine whether all four prongs of the Hall test are met." Id.

4. Remand.

The Plan Administrator's failure to provide adequate findings or to explain the grounds for denial of benefits "does not mean that the claimant is automatically entitled to benefits because such a holding might provide the claimant with an economic windfall should she be determined not disabled upon a proper reconsideration." Hackett v. Xerox Corp. Long-Term Disability Income Plan, 315 F.3d 771, 776 (7th Cir. 2003)(internal quotations omitted). Rather, if the Plan Administrator "fail[s] to make adequate findings or to explain adequately the grounds of [its] decision, the proper remedy is to remand the case to the administrator for further findings or explanation." DeGrado v. Jefferson Pilot Fin. Ins. Co., 451 F.3d 1161, 1175 (10th Cir. 2006)(internal quotations omitted).

The Tenth Circuit explained in Caldwell v. Life Insurance Co. of North America, 287 F.3d 1276 (10th Cir. 2002), that

> ERISA section 1133(1) requires that a claims administrator provide adequate notice to any participant whose claim has been denied, "setting forth the specific reasons for such denial. . . . The remedy when an ERISA [*42] administrator fails to make adequate findings or to explain adequately the grounds of her decision

> is to remand the case to the administrator for further findings or explanation. A remand for further action is unnecessary only if the evidence clearly shows that the administrator's actions were arbitrary and capricious . . . or the case is so clear cut that it would be unreasonable for the [P]lan [A]dministrator to deny the application for benefits on any ground.

Id. at 1288 (internal quotations and citations omitted). See Gallo v. Amoco Corp., 102 F.3d 918 (7th Cir. 1996)(stating that "[t]he remedy when a court or agency fails to make adequate findings or to explain its grounds adequately is to send the case back to the tribunal for further findings or explanation. . . . This is the appropriate remedy in an ERISA case just as in a conventional appeal.")(internal citations omitted).

5. Provisions of Coverage and Exclusionary Clauses.

"Questions involving the scope of benefits provided by a plan to its participants must be answered initially by the plan documents, applying the principles of contract interpretation." Chiles v. Ceridian Corp., 95 F.3d 1505, 1515 (10th Cir. 1996). Applying [*43] this principle, the Tenth Circuit in Pirkheim v. First UNUM Life Insurance, 229 F.3d 1008 (10th Cir. 2000), reviewed policy language which stated: "'We agree with the Policyholder to cover each

Insured for any loss described in Part I in return for the payment of premiums and subject to the provisions which follow. The loss must result directly and independently of all other causes from accidental bodily injury which occurs while this policy is in force as to the Insured, herein called 'injury.'" 229 F.3d at 1009 (quoting policy)(emphasis added by Pirkheim v. First UNUM Life Insurance). In light of the terms "directly" and "independently," the Tenth Circuit in Pirkheim v. First UNUM Life Insurance concluded that the policy it was interpreting was unambiguous and that it imposed two conditions. "First, the loss must result directly from accidental bodily injury. Second, the loss must result independently of all other causes." Id. The Tenth Circuit therefore agreed with the district court that "the word 'directly' modifies the phrase 'from accidental bodily injury.' Any other interpretation in this context is contrived." Id.

Having interpreted the policy language, the Tenth Circuit in [*44] Pirkheim v. First UNUM Life Insurance denied parents accidental death benefits after their four-year old son, who was born with a congenital heart defect, died from pacemaker failure after the batteries inside the pacemaker were depleted. See id. at 1009. According to the Tenth Circuit, because the child's "death did not occur independent of all other causes, e.g., his cardiac arrhythmia," one of the policy conditions was not satisfied. Id. at 1011. "Accordingly, [the Tenth Circuit] . . . h[e]ld the [P]lan [A]dministrator did not err in denying accidental death benefits to [the plaintiffs]." Id.

In ERISA cases, it is "well-established that the burden is upon the insurer to demonstrate that the insured's claim falls within the terms of an exclusionary clause, and that such clauses are interpreted narrowly." Frerking v. Blue Cross-Blue Shield of Kan., 760 F. Supp. 877, 881 (D.Kan. 1991). In Fought v. UNUM Life Insurance Co. of America, 379 F.3d 997 (10th Cir. 2004), the Tenth Circuit dealt with disability insurance policy containing a clause which excluded coverage for preexisting conditions. The policy had a section heading styled "What disabilities are not covered under your plan?" which [*45] stated: "Your plan does not cover any disabilities caused by, contributed to by, or resulting from your . . . pre-existing condition." 379 F.3d at 999. While the policy at issue in Fought v. UNUM Life Insurance Co. of America did not define "caused by," "contributed to by," or "resulting from," it stated:

> [Y]ou have a pre-existing condition when you apply for coverage when you first become eligible if:
>
> - you received medical treatment, consultation, care or services including diagnostic measure or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 3 months just prior to your effective date of coverage; and

> - the disability begins in the first 12 months after your effective date of coverage.

379 F.3d at 999 (internal quotation marks omitted).

The policy holder in Fought v. UNUM Life Insurance Co. of America had undergone an elective coronary artery revascularization surgery during which the surgeon discovered that she had an abnormally narrow and osteoporotic sternum. See id. As a result, she required special procedures for treating [*46] the surgical wound. See id. For the next several months, the policy holder underwent a difficult and debilitating post-operation recovery because of complications with her surgical wound. See id. at 999-1000. The policy holder applied for, and was denied, long-term disability benefits under her policy on the grounds that a preexisting condition caused her disability. See id. at 1000.

With those facts in mind, the Tenth Circuit in Fought v. UNUM Life Insurance Co. of America stated:

> The major difficulty presented by this case is that UNUM's policy excludes coverage for disabilities caused by pre-existing conditions, whereas it seeks here to apply its policy as if it excludes coverage for disabilities caused by complications from surgery for pre-existing

> conditions. Surgery is not, of course, a pre-existing condition, but at most a necessary consequence of a pre-existing condition. In essence, therefore, this case becomes a matter of where we draw the line on chains of causation.

Id. at 1009. Facing the complex causation question that the policy's language created, the Tenth Circuit noted: "[The insurer] seems to suggest that it need not cover anything for which it can construct a but/for [*47] story. If we were to accept this contention, we would effectively render meaningless the notion of the pre-existing condition clause by distending the breadth of the exclusion." 379 F.3d at 1010. Furthermore, the Tenth Circuit emphasized a regulation from the Department of Labor, 29 C.F.R. § 2590.701-3(a)(1)(i)(C), to bolster its holding. See id. at 1010. The Tenth Circuit quoted the Practicing Law Institute's guidelines for interpreting 29 C.F.R. § 2590.701-3(a)(1)(i)(C). See Fought v. UNUM Life Ins. Co. of Am., 379 F.3d at 1010. Those guidelines provided that:

> Thus, before imposing a preexisting condition limitation, plan sponsors must carefully evaluate whether a particular condition is "directly attributable" to the preexisting condition. Medical conditions which merely "contribute towards" accidents or illnesses, but are not "directly attributable" to the preexisting

> condition may not be excluded. This causal connection requirement will undoubtedly open the door for arguments that preexisting conditions were not the "proximate cause" of a particular injury or sickness -- e.g., treatment of pneumonia for an individual who was previously diagnosed with AIDS.

Id. at 1010. The Tenth Circuit [*48] cited as an essential tenet of contract law the notion that exclusions must be read narrowly, and explained that an "exclusion cannot merely require that the pre-existing condition be one in a series of factors that contributes to the disabling condition; the disabling condition must be substantially or directly attributable to the pre-existing condition." Fought v. UNUM Life Ins. Co. of Am., 379 F.3d at 1010. Thus, the Tenth Circuit in Fought v. UNUM Life Insurance Co. of America held that "the plan's language . . . [did] not reasonably apply to the attenuated chain of events between the [claimant]'s pre-existing coronary artery disease and her disabling staph infection and that [the insurance company]'s denial of benefits was not supported by substantial evidence." 379 F.3d at 1015.

In Weis v. Accidental Death & Dismemberment Benefit Plan of Kaiser Foundation Health Plan Inc., 442 F.Supp.2d 850 (N.D.Cal. 2006), the plan participant was entitled to coverage for accidental injury to his eye as long as that injury was the predominant and

proximate cause of blindness in his eye. See 442 F.Supp.2d at 852-53. Although the claimant had congenital cataracts and a thirty-year history of eye [*49] problems, the evidence showed that he lost his eyesight after the accident. See id. at 855-56. While the district court recognized that his preexisting condition may well have contributed to the extent of his injuries, the district court nevertheless held that he was entitled to coverage as the accident was the proximate cause of his sight loss. See id. at 857.

In Buzzard v. Holland, 367 F.3d 263 (4th Cir. 2004), an ERISA case, the Fourth Circuit explained:

> We generally review the district court's order granting summary judgment de novo. . . . However, . . . the Supreme Court [has] held that a denial of benefits challenged under [ERISA] is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan. . . . If the plan confers such authority upon the [P]lan [A]dministrator, a deferential abuse of discretion standard applies to appellate review of the eligibility determination. . . . Because we have previously held that the 1974 Plan vests the Trustees with full and final authority to determine who is eligible for benefits, our review is limited to

> [*50] ascertaining whether the Trustees abused their discretion.

367 F.3d at 268 (internal quotations and citations omitted).

6. Attorney's Fees.

In any action brought by an ERISA plan participant, the court has discretion to award "a reasonable attorney's fee and costs of action to either party." 29 U.S.C. § 1132(g)(1)(stating that "[i]n any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party."). The granting of attorney's fees under ERISA is not to be done as a "matter of course, but is discretionary in nature." Gordon v. United States Steel Corp., 724 F.2d at 108. There is a general disfavoring of attorney fee awards in ERISA cases. See San Francisco Culinary, Bartenders and Serv. Employees Welfare Fund v. Lucin, 76 F.3d 295, 298 (9th Cir. 1996)("A denial of attorney's fees in this case would also be consistent with the general disfavoring of attorney fee awards in ERISA cases.").

The Tenth Circuit listed several factors in Gordon v. United States Steel Corp. for deciding if an award of attorney's fees and costs in an [*51] ERISA action are appropriate, including: (i) the degree of the opposing parties' culpability or bad faith; (ii) the ability of the opposing parties to personally satisfy an award of attorney's fees; (iii)

whether an award of attorney's fees against the opposing parties would deter others from acting under similar circumstances; (iv) whether the parties requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA; and (v) the relative merits of the parties' position. See Gordon v. United States Steel Corp., 724 F.2d at 109; McGee v. Equicor-Equitable HCA Corp., 953 F.2d 1192, 1209 n. 17 (10th Cir. 1992). In Atwood v. Swire Coca-Cola, 482 F.Supp.2d 1305 (D. Utah 2007), a court awarded attorneys fees when

> [t]here [wa]s no evidence of bad faith on the part of [the defendant]. But certainly [the defendant]'s culpability has been established, and that culpability outweighs any that might be attributed to [the claimant]. The court also finds that Swire, a large corporation with thousands of employees, has the ability to satisfy an award of attorney's fees and costs. As for the third factor, an award of attorney's [*52] fees here would deter other [P]lan [A]dministrators from so cavalierly treating an employee's benefit application. The fourth factor is not applicable in this situation, for [the claimant]'s claim only indirectly benefited participants and beneficiaries (and no significant legal question was presented to the court). Finally, the fifth factor certainly

> weighs in favor of [the claimant], who ultimately prevailed in this court despite [the defendant]'s arguments. Given the court's analysis of the above cited factors, as well as the court's concern that Swire attempted to place the blame completely on [the claimant], the court finds that [the claimant] is entitled to reasonable attorney's fees and costs.

Id. at 1317-18. Motions for attorney fees are separate from and collateral to any decision on the merits. See White v. New Hampshire, 455 U.S. 445, 451-52, 102 S. Ct. 1162, 71 L. Ed. 2d 325 (1982)(stating that "[r]egardless of when attorney's fees are requested, the court's decision of entitlement to fees will therefore require an inquiry separate from the decision on the merits -- an inquiry that cannot even commence until one party has 'prevailed' while discussing attorney's fees under 42 U.S.C. § 1988").

LAW REGARDING [*53] **MOTIONS TO STRIKE**

A motion to strike is limited to challenges of pleadings, and is not appropriate to question motions or memoranda. See E.E.O.C. v. Roswell Radio, Inc., No. CIV-06-0253 JB/LAM, 2007 U.S. Dist. LEXIS 56488, 2007 WL 2305521 at * 8 (D.N.M. June 12, 2007)(Browning, J.)(citing Searcy v. Soc. Sec. Admin., No. 91-4181, 956 F.2d 278 (Table), [published in full-text format at 1992 U.S. App. LEXIS 3805], 1992 WL 43490, at *2

(10th Cir. March 2, 1992)("[T]here is no provision in the Federal Rules of Civil Procedure for motions to strike motions and memoranda.")). "Only material included in a 'pleading' may be the subject of a motion to strike, and courts have been unwilling to construe the term broadly. Motions, briefs, or memoranda, objections, or affidavits may not be attacked by the motion to strike." J. Moore, Moore's Federal Practice § 12.37[2], at 12-128 to 12-129 (3d ed. 2005). The Federal Rules of Civil Procedure define "pleadings" as a complaint or third-party complaint; an answer to a complaint, a third-party complaint, a counterclaim, or a crossclaim; and, "if the court orders one, a reply to an answer." FED. R. CIV. P. 7(a)(1-7). See Searcy v. Soc. Sec. Admin., 1992 U.S. App. LEXIS 3805, 1992 WL 43490, *1, *4 (affirming, "for substantially the same reasons set forth" in the attached [*54] Magistrate Judge's Report and Recommendation the recommendation that a motion to strike the defendant's motion to dismiss should be denied because "there is no provision in the Federal Rules of Civil Procedure for motions to strike motions and memoranda")(unpublished); Applied Capital, Inc. v. Gibson, No. Civ. 05-98 JB/ACT, 2007 U.S. Dist. LEXIS 97752, 2007 WL 5685131, *7 & *18 (D.N.M. Sep 27, 2007)(Browning, J.)(citing Searcy v. Soc. Sec. Admin.), and refusing to strike motion to dismiss because "[m]otions to strike are reserved for striking pleadings"); Coleman v. City of Pagedale, No. 4:06-CV-1376 ERW, 2008 U.S. Dist. LEXIS 3174, 2008 WL 161897, *4 (E.D.Mo. Jan. 15, 2008)(holding that a sur-reply and memorandum

were not pleadings and could not be attacked with a motion to strike).

The exception to this principle is that a Court may "choose to strike a filing that is not allowed by local rule, such as a surreply filed without leave of court." Superior Prod. P'ship v. Gordon Auto Body Parts Co., No. 06-cv-916, 2008 U.S. Dist. LEXIS 42521, 2008 WL 2230774, at *1 (S.D. Ohio May 28, 2008). See In re Hopkins, No. 98-1186, 162 F.3d 1173, 1998 WL 704710, *3 n.6 (10th Cir. Oct. 5, 1998)(holding that, because party's "briefs were non-complying . . . it was well within the discretion [*55] of the district court to strike them")(unpublished); Jones v. United Space Alliance, L.L.C., No. 05-13001, 170 Fed. Appx. 52, 57 (11th Cir. Feb. 3, 2006)(holding that court did not abuse its discretion in striking a motion that violated the district's local rules)(unpublished).

ANALYSIS

A careful review of the sparse administrative record convinces the Court that the most appropriate course of action at this stage is to remand the case to the Plan Administrator for more complete findings. The Plan Administrator gave only one reason for denying benefits, and the Tenth Circuit has found that reason to be erroneous. The parties still dispute, however, whether either Monumental Life or Miller should be entitled to summary judgment on other grounds. The Court does not believe that Monumental Life has waived the sole-cause argument or should be estopped from raising it.

While the Court concludes that the sole-cause requirement is not an exclusion, and that it should be interpreted similarly to the "directly" and "independently" language that the Tenth Circuit discussed in Pirkheim v. First Unum Life Ins., the Court believes the administrative record provides insufficient basis for a determination [*56] of whether there is a genuine issue of material fact on the sole cause question. The Court also believes that the question whether Miller is Totally Disabled, which represents another requirement for receiving CDB, is open despite some language in the Tenth Circuit opinion in this case suggesting otherwise. The Court will also deny the motion to strike and, at this stage, the request for attorney's fees.

I. MONUMENTAL LIFE HAS NOT WAIVED THE SOLE-CAUSE AND TOTAL-DISABILITY ARGUMENTS.

There are two primary reasons why the Court finds that Monumental Life has not waived the ability to argue the sole-cause and Totally Disabled issues. First, the record does not clearly illuminate what was argued to the Plan Administrator. There is no indication, however, that the sole-cause issue ever came up. One of the problems plaguing this case is the paucity of the record. The parties' briefing on the sole-cause issue is replete with arguments about what the administrative record contains, and about what arguments were raised to the Plan Administrator. The parties, however, fail to provide record citations or references to documents or to anything else that could amount

to evidence of what constitutes [*57] the administrative record. The Court suspects that there is no formal record, such as what would be produced in an administrative hearing in front of a governmental agency. With no definitive record, the Court cannot say that Monumental Life failed to raise anything at the administrative level, such that it should be precluded from doing so now.

Second, the Court agrees with the Eight Circuit's holding in Weber v. St. Louis University, which stated that, when conducting a de novo review of a denial of benefits under an ERISA plan, "a trial court must consider all of the provisions of the policy in question if those provisions are proffered to the trial court as a reason for denial of coverage." 6 F.3d at 560. The Eighth Circuit in Weber v. St. Louis University stated that such a course of action was proper, "even if those provisions were not 'specified . . . as the basis of denial of coverage.'" Id. (quoting Farley v. Benefit Trust Life Insurance Co., 979 F.2d 653, 660 (8th Cir. 1992))(ellipsis in Weber v. St. Louis University).

The reasoning that the Eight Circuit marshaled in Weber v. St. Louis University is persuasive. The Eighth Circuit explained that to prevent a party from raising [*58] other provisions which would preclude coverage would "permit the oral modification of employee welfare plans governed by ERISA, a result manifestly in conflict with the intent of the statute and with the case law governing it." Id. (internal quotation marks omitted). Without the ERISA framework overlaying this lawsuit, the dispute between

Monumental Life and Miller would be a common-law contract case, and the Court's review of the denial benefits would largely consist of interpreting the contract provisions. Although ERISA alters the setting, it does not compel treatment of the Plan Administrator as analogous to a governmental administrative agency "whose decisions are subject to limited judicial scrutiny." 6 F.3d at 560. "Nor, in our view, are the materials considered by a plan administrator strictly analogous to a 'record,' in the sense that the courts use that term to describe the basis for a prior adjudication by a governmental administrative agency." Id.

Miller argues that to allow Monumental Life to argue an "exclusion" for sole cause would be "without an administrative record rendered after notice and an opportunity to be heard." See Memo. at 6. Miller's fear of not having an [*59] opportunity to be heard is overwrought, given the protracted nature of this case. Moreover, the Court is able to, and has, allowed the parties to make arguments about the sole-cause issue. The Court's decision to remand this case to the Plan Administrator also alleviates any danger that due process will be denied because the parties will have the opportunity to raise their concerns to the Plan Administrator regarding sole cause. Thus, there will be no unfair surprise wrought upon either party. And, if the Court were to determine that the sole-cause - or the Total-Disability - issue was waived or finally determined in Miller's favor, the Court would be perpetrating a miscarriage of justice. The Court is not aware that there was a formal hearing in the

front of the Plan Administrator. Rather, the Plan Administrator received the relevant documentation of Miller's injuries and then issued a letter stating her reasons for rejecting coverage. She did not decide whether Miller was Totally Disabled or whether the work injury was the sole cause of any disability.

To now foreclose argument on those issues based on the fact that the Plan Administrator did not base her decision on them would have [*60] the effect of granting a potential windfall to Miller. If the Plan Administrator did not reach the sole-cause issue, but would have otherwise found Miller unable to establish sole cause if not for the finding on SSI benefits, Miller would effectively be able to receive CDB without having to establish that he met all of the requirements for those benefits. In other words, Monumental Life would be forced to pay out benefits to someone not entitled to those benefits merely because the litigation posture of this case brought about the situation where the Tenth Circuit found that, as a matter of law, Miller had established one of the four elements he needed for his claim to benefits. The risk of such a windfall underscores the wisdom in the Eight Circuit's opinion in Weber v. St. Louis University mandating that a district court consider all policy provisions which the insurer raises that could potentially disallow benefits. By considering all pertinent provisions that the Plan Administrator raises, the Court assures that Miller remains liable to show he meets all of the requirements for CDB.

Furthermore, the Court avoids effectively re-writing the Policy, which requires an insured to prove [*61] that he meets the criteria for CDB. See Policy at 10. The Court is not willing to apply waiver or estoppel under the circumstances of this case to draw a line through the policy language requiring proof or the policy language laying out the elements that the policy holder must prove.

The Court is also reluctant to create a rule that imposes a burden on plan administrators duties that may make this job more complicated and claim resolution more expensive. Currently, plan administrators make quick decisions, and communication between administration and claimant is often informal. One issue is often determined, providing quick resolution of most claims. It does not benefit insurance companies or claimants to require plan administrators to decide every possible issue before there is an appeal, else the parties are estopped for raising any new issues.

To impose such a formal requirement on plan administrators would likely undercut the efficiency that ERISA was designed to guarantee. The federal appellate courts encourage district courts not to decide questions they do not have to decide, and when new issues are raised on appeal, decline to consider them and remand them to the district court. [*62] The Court should not fashion a rule for plan administrators that is more formal and onerous than what the appellate courts require of district courts.

The Court recognizes that there is an element of burden and that it is perhaps unfair to require Miller to litigate all the way to the Tenth Circuit, to allow Monumental Life to lose on the one issue on which it provided before the plan administrators, and then allow Monumental Life to return to the Plan Administrator to litigate another issue. The Court would be reluctant to remand except under extraordinary circumstances. Those circumstances appear to be present in this case. The Plan Administrator's record is thin, not clearly revealing what was advanced before her. Yet to formally grant summary judgment for Miller because the Plan Administrator did not rely on the sole cause could give Miller a windfall. Fairness dictates that the Plan Administrator explore this issue before the Court tries to determine these issues on the incomplete record it has.

II. THE SOLE-CAUSE REQUIREMENT IS NOT AN EXCLUSION.

One of the primary legal questions that emerges from the parties' briefing is the distinction between an exclusion under a policy and a [*63] requirement for coverage. In some sense, the distinction may appear hollow. Nevertheless, such a distinction is important to the outcome of this case. First, the difference between a policy provision and an exclusion weighs upon the determination of who, between the policy-holder and the insurer, has the burden of proving either entitlement or disentitlement to coverage. Second, the difference impacts which Tenth Circuit case law governs the analysis in

this case regarding the interpretation of the sole-cause requirement.

A. MILLER HAS THE BURDEN OF PROVING THAT HE QUALIFIES FOR COVERAGE BECAUSE THE SOLE-CAUSE PROVISION IS A REQUIREMENT FOR COVERAGE AND NOT AN EXCLUSION.

The Tenth Circuit has stated that, under basic contract-interpretation principles, a district court should interpret policy exclusions narrowly. See Fought v. UNUM Life Ins. Co. of Am., 379 F.3d at 1010. Moreover, federal courts have held that the insurer has the burden of proving exclusions, such as for preexisting conditions. See Strickland v. Transamerica Ins., Co., 481 F.2d 138, 149 n.12; Farley v. Benefit Trust Life Ins. Co., 979 F.2d at 658 (agreeing that it was the beneficiary's burden to show that he was entitled [*64] to the benefits under the terms of his plan). In contrast, policy exclusions are often characterized as affirmative defenses. See 5 C. Wright & A. Miller, FEDERAL PRACTICE AND PROCEDURE 1271, at 588-89 (3d ed. 2004). The distinction between an exclusion and a provision of coverage is therefore important because it impacts which party has the burden of proof. See Frerking v. Blue Cross-Blue Shield of Kan., 760 F. Supp. 877, 881 (D.Kan. 1991)(finding it "well-established that the burden is upon the insurer to demonstrate that the insured's claim falls within the terms of an exclusionary clause, and that such clauses are interpreted narrowly").

The Policy in this case has separate sections describing the requirements for coverage and the

exclusions. The Policy contains a separate section entitled **GENERAL EXCLUSIONS AND LIMITATIONS**. Even though there is obviously some relationship between the sole-cause requirement that appears in the section defining qualifications for CDB and certain limitations in the exclusions section, the section defining the requirements states: "We will pay the benefit described below to an Insured Person when We received due proof " that the requirements, including [*65] sole cause, are met. Policy at 10 (emphasis added). In other words, the Policy unambiguously places the burden on the policy holder seeking benefits to prove the work injury was the sole cause of the disability. While the policy holder bears the burden of establishing sole cause and the other requirements for receipt of benefits, the Tenth Circuit has held that the insurer must prove that exclusions apply. The Policy in this case separates coverage requirements from exclusions, and the Court will respect that division.

B. PIRKHEIM V. FIRST UNUM LIFE INS. APPLIES TO THIS CASE AND SUPPORTS A FINDING THAT THE SOLE-CAUSE PROVISION IS UNAMBIGUOUS.

The parties have cited two Tenth Circuit cases that might control the outcome of this case. Monumental Life relies heavily on Pirkheim v. First Unum Life Ins., while Miller argues that Fought v. UNUM Life Ins. Co. of Am. is more on point. A careful review of both cases convinces the Court that Monumental Life has applied the correct legal authority to the facts of this case.

Miller seeks to argue out from under Pirkheim v. First Unum Life Ins. by pointing out some ways in which the facts surrounding the disability in that case differ from the facts [*66] surrounding the disability in this case. While the Court does not discount Miller's arguments, the Court believes the the similarities in the language and structure of the policy in Pirkheim v. First Unum Life Ins. to the language and structure of the policy at issue in this case suggest that Pirkheim v. Unum Life Ins. should apply in this case. An important distinction between Fought v. UNUM Life Ins. Co. of Am. and Pirkheim v. First Unum Life Ins. is that, in Fought v. UNUM Life Ins. Co. of Am., the policy provision in question was an exclusion, while in Pirkheim v. First Unum Life Ins., the Tenth Circuit was dealing with a provision of coverage. It is that determination that led the Tenth Circuit in Fought v. UNUM Life Ins. Co. of Am. to interpret the policy language in question narrowly.

The policy language in Fought v. UNUM Life Ins. Co. of Am. was also fraught with ambiguities and left key terms undefined. The policy had a section heading styled "What disabilities are not covered under your plan?" which stated: "Your plan does not cover any disabilities caused by, contributed to by, or resulting from your . . . pre-existing condition." 379 F.3d at 999. While the policy at issue [*67] in Fought v. UNUM Life Insurance Co. of America did not define "caused by," "contributed to by," or "resulting from," it stated:

> [Y]ou have a pre-existing condition when you apply for coverage when you first become eligible if:
>
> - you received medical treatment, consultation, care or services including diagnostic measure or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; or you had symptoms for which an ordinarily prudent person would have consulted a health care provider in the 3 months just prior to your effective date of coverage; and
>
> - the disability begins in the first 12 months after your effective date of coverage.

379 F.3d at 999 (internal quotation marks omitted).

The terms "caused by," "contributed to," and "resulting from" failed to set the metes and bounds for when the causal relationship between the preexisting condition and the disability became sufficient to compel a denial of coverage. Thus, given the policy's ambiguity and the necessity of interpreting the exclusionary provision narrowly, the Tenth Circuit in Fought v. UNUM Life Insurance Co. of America found that "[the insurer's] expansive reading of the exclusion may be [*68] overly broad: The exclusion cannot merely require that the pre-existing condition be one in a series of factors that contributes to the disabling condition; the

disabling condition must be substantially or directly attributable to the pre-existing condition." Id. at 1011. Accordingly, "the plan's language . . . [did] not reasonably apply to the attenuated chain of events between the [claimant]'s pre-existing coronary artery disease and her disabling staph infection and that [the insurance company]'s denial of benefits was not supported by substantial evidence." 379 F.3d at 1015.

Because the Tenth Circuit in Pirkheim v. First UNUM Life Insurance was not dealing with an exclusion, and because it was not dealing with ambiguous language, the Tenth Circuit did not have to engage in the complex causation analysis that it did in Fought v. UNUM Life Insurance Co. of America. The policy in Pirkheim v. First UNUM Life Insurance stated: "'We agree with the Policyholder to cover each Insured for any loss described in Part I in return for the payment of premiums and subject to the provisions which follow. The loss must result directly and independently of all other causes from accidental bodily [*69] injury which occurs while this policy is in force as to the Insured, herein called 'injury.'" 229 F.3d at 1009 (quoting policy)(emphasis added by Pirkheim v. First UNUM Life Insurance). The requirement that a loss result "directly and independently" was unambiguous in the Tenth Circuit's view.

The Policy in this case provides, in a fashion similar to the policy in Pirkheim v. First UNUM Life Insurance: "We will pay the benefit described below to an Insured Person when We receive due

proof that: (1) he is Totally Disabled; and . . . such Total Disability . . . resulted solely and directly from Injury while insured under the Group Policy . . . ." Policy at 10. The Policy in this case is therefore structured similarly to the policy in Pirkheim v. First UNUM Life Insurance. The Policy in Pirkheim v. First UNUM Life Insurance required the loss to "result directly and independently of all other causes" while the policy in this case requires proof that the injury "resulted solely and directly" from the work injury. Both policies use the word "result" and both use "directly." Moreover, the Court sees very little meaningful distinction, as far as this case is concerned, between "independent [*70] of all other causes" and "solely" as those terms are used in the respective policies. "Solely," like "independent of all other causes," seeks to say the same thing: the covered injury must be the only cause. The Tenth Circuit interpreted the "directly and independently" language in such a fashion and upheld a denial of benefits because a child's "death did not occur independent of all other causes, e.g., his cardiac arrhythmia," and thus one of the policy conditions was not satisfied. Id. at 1011.

Given the Tenth Circuit's analysis in Pirkheim v. First UNUM Life Insurance, the Court must apply similar analysis in this case. Accordingly, the Court finds that the Policy in this case, like the policy at issue in Pirkheim v. First UNUM Life Insurance, requires the policy holder to prove that his disability resulted solely from the work injury. If the work injury alone

was not the cause, then Miller is not entitled to coverage.

III. THE TENTH CIRCUIT DID NOT DECIDE THAT MILLER HAS ESTABLISHED TOTAL DISABILITY UNDER THE POLICY.

The Court is not convinced that the Tenth Circuit has decided that Miller has proved Total Disability, which the Policy requires as a condition of coverage. Nevertheless, [*71] certain language from the Tenth Circuit's Opinion reversing the Court's Memorandum Opinion and Order in this case gives the Court pause. Specifically, there are various passages in the Tenth Circuit's opinion that might suggest that the Tenth Circuit found that Miller established that, by receiving an SSI benefit based on disability, Miller established that he is Totally Disabled under the Policy. The Tenth Circuit stated:

> It is clear that the Plan's requirement of a Social Security Disability Award serves as a delegation of substantive disability determinations to the SSA. The Plan mandates that a beneficiary be incapable of engaging in productive labor. However, it provides no mechanism for assessing his physical condition, other than whether he has received a Social Security Disability Award.

Miller v. Monumental Life Ins., Co., 502 F.3d at 1251. The Tenth Circuit also explained: "In light of his physical impairments, education, and job skills, the SSA concluded that Mr. Miller was 'unable to perform every duty pertaining to any occupation for which he is or may become qualified by education, training, or experience. . . .' " Id. at 1251 (quoting SSI Decision). The Tenth Circuit noted [*72] that "[t]his finding seems to satisfy the Plan's requirement that a recipient of Continuous Benefit be 'unable to perform the physical and mental requirements of any past relevant work.'" Id. (citations omitted).

Although this language troubles the Court, in the end, the Court does not believe the Tenth Circuit decided that it was established that Miller was Totally Disabled. "Seems" is not the word the Tenth Circuit would likely have chosen to demarcate a holding. In identifying the relationship between the Policy's definition of Total Disability and the requirement for an award of Social Security Disability benefits, the Tenth Circuit intended to illustrate that a reasonable policy holder would equate an SSI benefit with an SSD benefit. It is for that reason that the Tenth Circuit pointed out that the SSA's finding seems to satisfy the disability requirement.

The Court does not believe the Tenth Circuit meant to further hold that the disability prong was, in fact, met. Accordingly, whether the Total Disability requirement has been met remains an open question that will have to be further developed with the Plan Administrator.

Moreover, the Policy specifies that the policy holder must [*73] prove that the Total Disability "began within the Disability Commencement Period," "continued without interruption for at least the Waiting Period," and "is reasonably expected to continue without interruption until the Insured Person dies." Policy at 10.

Moreover, the Court did not remand the case to the Court with instructions to enter judgment for Miller on the sole-cause issue or on any other basis. Instead, the Tenth Circuit remanded the case to the Court to address the issue whether Miller's work-related injury was the "sole cause" of his disability. Miller v. Monumental Life Ins. Co., 502 F.3d at 1255. The Tenth Circuit explained: "We note that Monumental [Life] also moved for summary judgment on the grounds that Mr. Miller's accident was not the 'sole cause' of his disability. . . . Because the district court did not address this issue, we must remand for further proceedings." Id. While the Court has been careful to read and re-read multiple times the Tenth Circuit's opinion, and wants very much to follow its directions, and is troubled by certain language in the opinion, the Court concludes that the Tenth Circuit did not decide the issue of Total Disability and remanded that [*74] issue to this Court to address it further.

Miller cites various cases from other jurisdiction to support his argument that the sole-cause language in the Policy should be interpreted narrowly to allow for coverage where the injury is a proximate or substantial cause of the disability. In other words, Miller wishes the

Court to ignore the actual language of the Policy and construe it in his favor. The authorities Miller cites do not persuade the Court to do so.

Miller cites, for example, Robertson v. Connors, 848 F.2d 472 (4th Cir. 1988), a case brought under the United Mine Workers of America Pension Fund in which the United States Court of Appeals for the Fourth Circuit interpreted the phrase "as a result of a mine accident" to require that the claimant show proximate cause. See id. at 475. The Fourth Circuit had to determine whether the Trustee's finding that a mine accident was not substantially responsible for the claimant's disability was arbitrary and capricious. See id. The Fourth Circuit stated:

> The only reasonable interpretation of the requirement that total disability be "the result of a mine accident," therefore, is that it requires total disability to have been proximately [*75] caused by the mine accident. That is, if the plaintiff was injured in a mine accident and that injury, whether in combination with a previous or subsequent condition, is substantially responsible for plaintiff's inability to perform his job and for whatever medical and vocational reasons he is unable to perform an alternative job, then his total disability results from a mine accident.

Id. at 475 (quoting Horn v. Mullins, 498 F.Supp. 1197, 1200 (W.D.Va. 1980), aff'd, 650 F.2d 35 (4th Cir. 1981)). Underpinning the Fourth Circuit's reasoning was another opinion springing out of a claim of benefits under the United Mine Workers of America Pension Fund from the Western District of Virginia, in which the district court had explained:

> [T]he determination of whether an individual is disabled necessarily involves vocational as well as medical considerations. A back injury which precludes an individual from performing his usual job would rarely prevent performance of light and sedentary activities. However, whether an individual with such an injury could meet the vocational demands of light or sedentary employment is an obviously different matter. The test for disability is a functional one, [*76] and a requirement that a mine accident injury alone preclude alternative work fails to take that fact into account. Given such a requirement, a plaintiff could establish that a mine accident injury is substantially responsible for preventing him from returning to his usual job, but, because other medical conditions or vocational factors preclude alternative work, it could be found that his total disability did not result from a mine accident. The only reasonable interpretation of the

> requirement that total disability be "the result of a mine accident," therefore, is that it requires total disability to have been proximately caused by the mine accident. That is, if the plaintiff was injured in a mine accident and that injury, whether in combination with a previous or subsequent condition, is substantially responsible for plaintiff's inability to perform his job and for whatever medical and vocational reasons he is unable to perform an alternative job, then his total disability results from a mine accident.

Horn v. Mullins, 498 F.Supp. at 1200. Such an interpretation of the language at issue in cases brought under the United Mine Workers of America Pension Fund might make sense. The language [*77] setting forth the requirement that the disability "result" from the mine accident did not contain further qualifications, such as "solely," "directly," or "independently," like the language at issue in this case. In light of the fact that a determination of Total Disability in this case also turns on both vocational and medical consideration, the Court can imagine the Tenth Circuit ruling in a similar fashion as the Fourth Circuit or the Western District of Virginia when faced with the same or similar language. Regardless, the Tenth Circuit has already interpreted a clause like the one in this case, which contained the limiters "directly" and

"independently." Pirkheim v. First UNUM Life Insurance, 229 F.3d at 1009. The Tenth Circuit read those two limiting phrases to impose two conditions: "First, the loss must result directly from accidental bodily injury. Second, the loss must result independently of all other causes." Id. It is therefore likely that the Tenth Circuit would read the language of the Policy at issue in this case, which uses the words "solely" and "directly," to similarly impose two requirements such as those that the policy discussed in Pirkheim v. First UNUM Life [*78] Insurance imposed.

Miller also cites Weis v. Accidental Death & Dismemberment Ben. Plan, 442 F. Supp. 2d 850 (N.D. Cal. 2006), in which a federal magistrate judge interpreted a policy that covered "bodily injury caused by an accident . . . and resulting directly and independently of all other causes" as being satisfied by a showing that the accident proximately caused the injury. 442 F. Supp. 2d at 851. The magistrate judge applied the doctrine of reasonable expectations, which the United States Court of Appeals for the Ninth Circuit had adopted as part of the federal common law. See id. Employing the doctrine of reasonable expectations, the magistrate judge explained that claimant had only received a copy of the Summary Plan Description and not the policy itself. See id. The Summary Plan Description stated: "'Accidental Death and Dismemberment benefits are not payable for death and dismemberment due to: most natural illnesses or diseases.'" Weis v. Accidental Death & Dismemberment Ben. Plan, 442 F. Supp. 2d at 851 (quoting Summary Plan Description).

Because the claimant did not receive a copy of the policy and only had the Summary Plan Description, the magistrate judge stated: "The [*79] [Summary Plan Description]'s more generous language could reasonably create different expectations than the more onerous language of the Policy. In such cases, the language most favorable to Plaintiff controls . . . ." Weis v. Accidental Death & Dismemberment Ben. Plan, 442 F. Supp. 2d at 853. The magistrate judge also explained:

> Any burden of uncertainty created by careless or inaccurate drafting of the summary must be placed on those who do the drafting, and who are most able to bear that burden, and not on the individual employee, who is powerless to affect the drafting of the summary or the policy and ill equipped to bear the financial hardship that might result from a misleading or confusing document. Accuracy is not a lot to ask.

Weis v. Accidental Death & Dismemberment Ben. Plan, 442 F. Supp. 2d at 853 (quoting Bergt v. Ret. Plan For Pilots Employed by MarkAir, Inc., 293 F.3d 1139, 1145 (9th Cir. 2002)).

Weis v. Accidental Death & Dismemberment Ben. Plan does not counsel the outcome of this case. While the policy at issue in that case was similar to the Policy in this case, the magistrate judge did not apply the Policy language strictly. Rather, a set of circumstances not present here

[*80] - i.e., the policy holder was presented with a summary document that contained language that was more permissive than the actual policy language - led the magistrate judge to apply the doctrine of reasonable expectations. The Court agrees with the magistrate judge in Weis v. Accidental Death & Dismemberment Ben. Plan that there is something wrong about an insurance company representing coverage to be more permissive than it really is, and then using the more onerous language found in the policy to deny a claim for benefits. This case does not raise such a danger. Instead, there is no dispute that Miller had the Policy and could read its terms, and that Monumental Life has sought to apply the policy language that Miller has at his disposal. There is therefore no reason to apply the doctrine of reasonable expectations in this case.

Finally, Miller argues that the Tenth Circuit's opinion in this case requires that the district court apply federal common law to interpret the Policy and that, under federal common law, the Court should not read the "sole" and "directly" language in a literal fashion. The Court realizes that, applying the federal common law, the Tenth Circuit held that ambiguities [*81] should be construed against the drafter. While Miller contends that the "sole-cause" language is ambiguous, the Court does not believe the language is ambiguous, given the Tenth Circuit's treatment of nearly identical language in Pirkheim v. First UNUM Life Insurance.

IV. REMAND IS THE APPROPRIATE REMEDY IN THIS CASE, GIVEN THE LACK OF CLARITY IN THE RECORD.

Both parties in this case argue that they are entitled to summary judgment on sole cause. Both parties' arguments, however, lack citation to evidence that the Court can rely in determining whether either party or none is entitled to summary judgment. The Plan Administrator denied coverage without mentioning sole-cause. Moreover, there is little evidence on what the Plan Administrator relied to reach her conclusion to deny benefits. Under these circumstances, even in light of the Court's interpretation of the sole-cause language of the Policy, the most appropriate course of action is to remand to the Plan Administrator so that she can further develop her ruling, and so that the parties can create a record upon which the Plan Administrator and any reviewing court can properly rule.

A. THE PLAN ADMINISTRATOR DID NOT EXPLICITLY RELY UPON [*82] THE "SOLE CAUSE" LANGUAGE IN THE POLICY TO DENY MILLER BENEFITS.

The Plan Administrator's decision contains one hundred and one words, excluding salutations and other formalities. In its entirety, the body of the letter setting forth the decision reads:

> Based on a review of your policy terms it does not appear that you are eligible for continuous total disability.

> According to the terms of the policy in order to be eligible for continuous total disability you must be unable to engage in any gainful employment for which you can be reasonably trained for [sic].
>
> You must be awarded a social security disability award for injuries sustained from this accident of 9-15-97. The information you have provided to us from the social security office is for supplemental security income and not a social security disability award. Therefore, no benefits are available.

Plan Administrator's Letter at 1. Two things are evident from the letter. First, the Plan Administrator denied for one reason: the SSI benefit did not qualify as a social-security disability award. See id. Second, the Plan Administrator reviewed "information" Miller provided from the Social-Security office. Id. The Court assumes that the [*83] Plan Administrator was referring to the SSI Decision, which was in Miller's favor. If that is the case, then the Court can likely assume that the Plan Administrator had the SSI Decision and that the SSI Decision therefore represents part of the record.

The Plan Administrator's letter is silent regarding other bases for denial of coverage. One possible reason for this silence is that the Plan Administrator, having decided a dispositive issue, considered it unnecessary to proceed to

determining other issues, such as causation and Total Disability. The Court at least cannot infer from the Plan Administrator's letter that she had a position regarding issues other than the character of SSI benefits. Moreover, the fact that the parties did not make a record on this issues for the administrator is not surprising. The Plan Administrator received whatever documentation Miller was required to provide, and the Plan Administrator then applied her understanding of the policy. The process was not like an administrative adversarial proceeding.

B. THE CASE LAW CONVINCES THE COURT THAT A REMAND WOULD BE MORE APPROPRIATE THAN SUPPLEMENTATION OF THE ADMINISTRATIVE RECORD.

Under the circumstances of this [*84] case, where the record is inadequate for appropriate judicial decision-making, the Tenth Circuit recognizes two solutions: a court may allow the parties to supplement the record or the court may remand. The case law suggests that remand is the most appropriate course of action in this case. The Court will therefore remand the case to the Plan Administrator.

The Tenth Circuit has explained that when the Plan Administrator "fail[s] to make adequate findings or to explain adequately the grounds of [its] decision, the proper remedy is to remand the case to the administrator for further findings or explanation." DeGrado v. Jefferson Pilot Fin. Ins. Co., 451 F.3d 1161, 1175 (10th Cir. 2006)(internal quotations omitted).

The Tenth Circuit reasoned in Caldwell v. Life Insurance Co. of North America that

> ERISA section 1133(1) requires that a claims administrator provide adequate notice to any participant whose claim has been denied, "setting forth the specific reasons for such denial. . . . The remedy when an ERISA administrator fails to make adequate findings or to explain adequately the grounds of her decision is to remand the case to the administrator for further findings or explanation. A [*85] remand for further action is unnecessary only if the evidence clearly shows that the administrator's actions were arbitrary and capricious . . . or the case is so clear cut that it would be unreasonable for the [P]lan [A]dministrator to deny the application for benefits on any ground.

287 F.3d at 1288 (internal quotations and citations omitted). See Gallo v. Amoco Corp., 102 F.3d 918 (7th Cir. 1996)(stating that "[t]he remedy when a court or agency fails to make adequate findings or to explain its grounds adequately is to send the case back to the tribunal for further findings or explanation. . . . This is the appropriate remedy in an ERISA case just as in a conventional appeal.")(internal citations omitted).

On the other hand, the Tenth Circuit has also noted that, at times, it is appropriate for the district court to allow the parties to supplement the record before making a ruling. In a district court's review of an ERISA Plan Administrator's decision, a party seeking to introduce evidence from outside the administrative record must establish the four elements that the Tenth Circuit set out in Hall v. Union Life Insurance Co. of America, 300 F.3d at 1202. See Jewell v. Life Ins. Co. of North America, 508 F.3d at 1309. [*86] The Tenth Circuit explained: "[T]he best way for a district court to implement ERISA's purposes in this context is ordinarily to restrict de novo review to the administrative record compiled during the claim administration process, instead of taking new evidence, hearing witnesses, and the like." See Jewell v. Life Ins. Co. of North America, 508 F.3d at 1309. (internal quotations omitted).

> A party seeking to introduce evidence from outside the administrative record bears a significant burden in establishing that he may do so. In particular, [(i)] the evidence must be "necessary to the district court's de novo review;" [(ii)] the party offering the extra-record evidence must "demonstrate that it could not have been submitted to the [P]lan [A]dministrator at the time the challenged decision was made;" [(iii)] the evidence must not be "[c]umulative or repetitive;" nor [(iv)] may it be

> "evidence that 'is simply better evidence than the claimant mustered for the claim review.' "

Id. (quoting Hall v. Union Life Ins. Co. of Am., 300 F.3d at 1203 (quoting in turn Quesinberry v. Life Ins. Co. of N. Am., 987 F.2d at 1027)). The Tenth Circuit reiterated that the "exceptional circumstances" listed [*87] in Hall v. Union Life Insurance Co. of America "are not exceptions to the Hall rule; they are merely examples of circumstances that might militate in favor of a finding of necessity." Jewell v. Life Ins. Co. of N. Am., 508 F.3d at 1309. Thus, "[t]he existence of one or more of these circumstances does not make extra-record evidence automatically admissible, for if it did, then supplementation of the record would not be limited to unusual cases or extraordinary circumstances." Id. "District courts must conduct analysis case-by-case to determine whether all four prongs of the Hall test are met." Id.

Even though it is therefore clear that the Tenth Circuit recommends remand to the Plan Administrator under certain circumstances and allows supplementation of the record in the district court under limited circumstances, it is not clear how a district court should choose between those two courses of action. The practical differences between remand and supplementation, however, convince the Court that this case presents appropriate circumstances for a remand.

When it chose to grant district courts the flexibility to allow parties to supplement the Plan Administrator's record, the Tenth Circuit [*88] was primarily concerned with balancing competing risks. On the one hand, if district courts were promiscuous about allowing parties to supplement the record, the district courts might begin playing the role of substitute plan administrators and frustrate the speedy administration of justice. See Hall v. Union Life Insurance Co. of America 300 F.3d at 1201. On the other hand, it might be unfair to claimants because, before ERISA was enacted, claimants would have been able to supplement the record, and a prohibition on supplementing the record under ERISA would afford claimants less protection than they had before ERISA. Such a result would run counter to ERISA's purposes. See Hall v. Union Life Insurance Co. of America 300 F.3d at 1201.

The Tenth Circuit carved out a middle ground between the two extremes and set forth the circumstances where supplementing the record would be appropriate. Whether to remand, however, is based on a different set of considerations. One major risk of a court refusing to remand a case to the Plan Administrator where the record is inadequate is that a claimant could face unfair surprise if the court ruled that the claimant was not entitled to coverage for [*89] a reason that the Plan Administrator did not discuss. On the flip side, a Plan Administrator's failure to provide adequate findings or to explain the grounds for denial of benefits "does not mean that the claimant is

automatically entitled to benefits because such a holding might provide the claimant with an economic windfall should she be determined not disabled upon a proper reconsideration." Hackett v. Xerox Corp. Long-Term Disability Income Plan, 315 F.3d at 776. In other words, if the Court refused to remand and insisted on deciding on an incomplete or unclear record in favor of the claimant, the claimant might receive a windfall because he will receive benefits without having to fully prove he is entitled to those benefits.

Remand is therefore based mainly on the inadequacy or lack of clarity in the administrative record. A district court is not in a good position to conduct a review of a record if that record is not fully developed and before the court. This case fully implicates such concerns to a greater degree than the concerns that would counsel in favor of retaining the case and allowing the parties to supplement the record. The Court is concerned about ruling on an issue [*90] such as sole cause or Total Disability without first seeing what the Plan Administrator does with those issues. Each issue implicates highly specialized determinations based on medical evaluations which the Plan Administrator presumably faces on a routine basis.

At the hearing, Miller discussed the process that the Plan Administrator follows. The Court believes that the process illustrates why it is appropriate to send this case back. According to Miller's representations:

The administrator would send a letter saying it looks as though you failed to meet this requirement. We'll need to have additional evidence or we'll have to deny you at this time. I see those sorts of letters all the time. Frequently they're saying we can't decide this yet because you don't have an opinion from this doctor and we sent out disability statement to a doctor, things like that. So all the time you're going back and forth making sure that they get what they need in order to have the medical evidence in the record or you're telling them we're waiting for the Social Security decision we'll send that to you. So there is communication about genuine issues. But it doesn't and then when there's a final denial, [*91] even then you can if they said they'll usually say but if you have additional medical record you know or something to change our opinion you know you can then appeal it. There's a lot of mechanisms. You can come in later, too, if you have new evidence. I mean, the whole idea is that they're going to give you your disability if you show them you're entitled it's just a matter of getting your ducks in a row or getting your evidence in front of them.

Tr. at 23:3-24:3 (Court & Rawley). To the extent that Miller has accurately portrayed the Plan Administrator's review process, it is evident that the Plan Administrator can, if necessary, request further documentation from a claimant, contact the doctors whom the claimant has used, and reconsider her determination if the claimant brings back further evidence to establish entitlement. Thus, it is possible to develop a record in the administrative process, and it is possible to ascertain the basis upon which a Plan Administrator makes her decision. The problem in this case is that the Plan Administrator gave only one basis for denying benefits and was silent on the other elements of the Policy. The record does not reflect that the Plan Administrator [*92] determined whether the work injury was the sole cause of the disability or whether she believed evidence on that element was lacking. Until the Plan Administrator clarifies at what evidence it looked on the sole cause and other elements, the Court cannot review what the Plan Administrator did in a meaningful way.

Supplementing the recording is less useful than remand here because, even if the Court allows supplementation of the record, the Court would be putting itself in the shoes of the Plan Administrator and attempting to review this claim without the Plan Administrator having the opportunity to apply her expertise and make a determination on issues about which she was silent in the earlier letter. It is therefore more appropriate to allow the Plan Administrator to pass on these issues first.

V. THE COURT WILL DENY MONUMENTAL LIFE'S MOTION TO STRIKE.

Monumental Life's attempt to argue that the Court should strike Miller's motion for attorney's fees lacks merit. A motion to strike is limited to challenges of pleadings, and is not appropriate against motions or memoranda. See E.E.O.C. v. Roswell Radio, Inc., 2007 U.S. Dist. LEXIS 56488, 2007 WL 2305521 at * 8. "[T]here is no provision in the Federal Rules of Civil [*93] Procedure for motions to strike motions and memoranda." Searcy v. Soc. Sec. Admin., 1992 U.S. App. LEXIS 3805, 1992 WL 43490, at *2. Thus, the Court will deny Monumental Life's motion to strike Miller's supplemental brief.

VI. MILLER IS NOT ENTITLED TO ATTORNEY'S FEES.

The Court will deny Miller's request for attorney's fees. In an ERISA case, the court has discretion to award "a reasonable attorney's fee and costs of action to either party." 29 U.S.C. § 1132(g)(1)(stating that "[i]n any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party."). The granting of attorney's fees under ERISA is not to be done as a "matter of course, but is discretionary in nature." Gordon v. United States Steel Corp., 724 F.2d at 108. There is a general disfavoring of attorney fee awards in ERISA cases. See San Francisco Culinary, Bartenders and Serv. Employees Welfare Fund v.

Lucin, 76 F.3d at 298("A denial of attorney's fees in this case would also be consistent with the general disfavoring of attorney fee awards in ERISA cases.").

The Tenth Circuit listed several [*94] factors in Gordon v. United States Steel Corp. for deciding if an award of attorney's fees and costs in an ERISA action are appropriate, including: (i) the degree of the opposing parties' culpability or bad faith; (ii) the ability of the opposing parties to personally satisfy an award of attorney's fees; (iii) whether an award of attorney's fees against the opposing parties would deter others from acting under similar circumstances; (iv) whether the parties requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA; and (v) the relative merits of the parties' position. See Gordon v. United States Steel Corp., 724 F.2d at 109; McGee v. Equicor-Equitable HCA Corp., 953 F.2d at 1209 n.17.

Here, the Court cannot say that Monumental Life engaged in any culpable or bad-faith conduct. While the Tenth Circuit has decided Monumental Life's interpretation of its policy was erroneous, there is no indication that Monumental Life came to its conclusion in a bad faith way. Monumental Life's problem was that it wrote an ambiguous provision and did not express its intent clearly-not that Monumental Life acted in [*95] bad faith.

The second Gordon factor also does not support an award of fees. The record is silent about Monumental Life's ability to satisfy an

award of attorney's fees, but the Court assumes that Monument Life could satisfy any award. Nevertheless, that factor, without more, does not suggest that the Court should, at this time, shift Miller's expenses to Monumental Life.

It is unlikely that shifting Miller's fees to Monumental Life will deter others from acting like Monumental Life under similar circumstances. The dispute between Monumental Life and Miller was a genuine one, and it is not settled. A grant of fees in this case will probably not influence insurance companies one way or another when unresolved legal issues separate them.

The legal issue here appears to be sui generis. It has apparently not arisen before at Monumental Life. Monumental Life, and perhaps other insurance companies, can now simply draft around the issue if they wish. The Tenth Circuit's decision is unlikely to benefit more participants than Miller. While it is true that the Tenth Circuit's opinion is a published opinion, and established for the first time in the Tenth Circuit that courts should apply *contra* [*96] *preferentem* to construe ambiguous language in ERISA contracts, other circuits have so held, and the case is largely an application of established law to the facts of this case.

The reality is that the parties - both Miller and Monumental Life - urged the Court to apply state law at the district court level, and then, on appeal, Miller changed his position and argued that federal common-law applied. If Miller had argued that federal law applied in the district

court, he might had prevailed in the district court on the legal issue that he applied to the Tenth Circuit.

In any case, while Miller has prevailed on one issue at this stage, he has not yet prevailed in the case. Miller may be entitled to fees and costs at a later point. At this stage, with the background that fees are disfavored in ERISA cases, the Court believes that it should not, under the Gordon factors, award Miller his fees and costs.

At the hearing, Miller explained: "Certainly all I'm asking for is if we prevail that the Court would then allow us to submit the evidence concerning the hours and the times and all of that." Id. at 25:1-3 (Rawley). The Court does not see a problem with Miller having asked for attorneys fees [*97] in the manner that he did, and the Court has held that it will not strike his request for attorney's fees. At this stage, however, an award of attorney's fees in not appropriate. There is still more to be done in this case. The case will at least be remanded to the Plan Administrator for further review. If the parties cannot either accept the Plan Administrator's finding or settle this case, it is likely the case will return to the district court to review the Plan Administrator's determination. In sum, it is too early in the game to start talking about attorney's fees.

IT IS ORDERED that this case is remanded to the Plan Administrator for further proceeding consistent with this Memorandum Opinion and Order. Monumental Life Insurance Company's Motion to Strike Plaintiff's Supplemental Brief is

denied. The Plaintiff's request for an award of attorney's fees, interest, and costs is denied.

/s/ James O. Browning
UNITED STATES DISTRICT JUDGE

RODNEY MILLER,

Plaintiff-Appellant,

v.

MONUMENTAL LIFE INSURANCE COMPANY,

Defendant-Appellee.

No. 09-2110

UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

April 28, 2010, Filed

NOTICE: PLEASE REFER TO FEDERAL RULES OF APPELLATE PROCEDURE RULE 32.1 GOVERNING THE CITATION TO UNPUBLISHED OPINIONS.

PRIOR HISTORY: [*1] (D.C. No. 1:04-CV-00970-JB-RHS). (D. N.M.). Miller v. Monumental Life Ins. Co., 2009 U.S. Dist. LEXIS 43859 (D.N.M., Mar. 31, 2009)

COUNSEL: For RODNEY MILLER, Plaintiff - Appellant: Brian Gary Grayson, Bauman, Dow &

Leon, PC, Albuquerque, NM; James Rawley, Albuquerque, NM.

For MONUMENTAL LIFE INSURANCE COMPANY, Defendant - Appellee: Bernie E. Hauder, Adkerson, Hauder & Bezney, P.C., Dallas, TX; Bruce Sheldon McDonald, Lucinda R. Siembieda, Albuquerque, NM.

JUDGES: Before McKAY, Circuit Judge, BRORBY, Senior Circuit Judge, and EBEL, Circuit Judge.

OPINION BY: Monroe G. McKay

OPINION

ORDER AND JUDGMENT ·

> * After examining the briefs and appellate record, this panel has determined unanimously to grant the parties' request for a decision on the briefs without oral argument. *See* Fed. R. App. P. 34(f); 10th Cir. R. 34.1(G). The case is therefore ordered submitted without oral argument. This order and judgment is not binding precedent, except under the doctrines of law of the case, res judicata, and collateral estoppel. It may be cited, however, for its persuasive value consistent with Fed. R. App. P. 32.1 and 10th Cir. R. 32.1.

Rodney Miller appeals from an order of the district court remanding this ERISA benefits case to the Plan administrator for further proceedings. Because we lack jurisdiction over the district

court's [*2] order remanding the case, we dismiss the appeal.

BACKGROUND

This is the second time this case has come before us. *See Miller v. Monumental Life Ins. Co.*, 502 F.3d 1245 (10th Cir. 2007). As detailed in our prior decision, Mr. Miller was injured in an automobile accident in September 1997 while working for Aycox Transportation. Following the accident, he applied for and received Supplemental Security Income (SSI) benefits from the Social Security Administration. He then applied for the Continuous Total Disability Benefit (Continuous Benefit) under a master-group policy issued by defendant Monumental Life Insurance Company (Monumental).

In order to receive the Continuous Benefit under Monumental's policy, an applicant must satisfy four criteria. First, he must be "totally disabled," Aplt. App. at 10, that is, "unable to perform every duty pertaining to any occupation for which he is or may become qualified by education, training or experience[.]" *Id.* at 5. Second, he must have "been granted a Social Security Disability Award." *Id.* Third, the disabling injury must have "occurred while the Insured Person was at work performing the duties of his regular occupation." *Id.* at 10. Finally, the [*3] injury must have "resulted solely and directly from [the] Injury" and satisfy certain other temporal requirements under the policy. *Id.*

On November 19, 2003, a claims representative for the Plan administrator sent Mr. Miller a letter denying his claim. The letter explained the denial as follows:

> According to the terms of the policy in order to be eligible for continuous total disability you must be unable to engage in any gainful employment for which you can be reasonably trained for [sic].
>
> You must be awarded a social security disability award for injuries sustained from this accident of 9-15-97. The information you have provided to us from the social security office is for supplemental security income and not a social security disability award. Therefore no benefits are available.

Id. at 18.

Mr. Miller thereafter filed this suit under the Employee Retirement Income Security Act (ERISA) challenging Monumental's denial of his request for long-term disability benefits. Monumental moved for summary judgment, contending (1) Mr. Miller had not been granted a Social Security Disability Award; (2) his disability commenced more than six months from the date of injury; and (3) his disability had [*4] not occurred "solely and directly" from an accidental, on-the-job injury. *Id.* at 27. The district court granted the motion for summary judgment on the

basis that the SSI benefit did not constitute a "Social Security Disability Award." It did not reach Monumental's other arguments.

Mr. Miller appealed, and we reversed the district court. *Miller*, 502 F.3d at 1255. We concluded that Mr. Miller's "Title XVI [SSI] award coupled with a finding of disability satisfied the Social Security Disability Award requirement." *Id.* We further concluded that the SSA's finding also appeared to satisfy the Plan's disability requirement, "that a recipient of Continuous Benefit be 'unable to perform the physical and mental requirements of any past relevant work.'" *Id.* at 1251. Noting that Monumental had moved for summary judgment on the alternate ground that Mr. Miller's accident was not the "sole cause" of his disability, we remanded for the purpose of permitting the district court to address this issue. *Id.*

On remand, the district court entered the extensive order that forms the basis of this appeal. It determined, first, that although Monumental had not relied on the "solely and directly" clause in its [*5] policy to deny benefits, coverage cannot be created by waiver or estoppel and Monumental could therefore raise the issue for the first time in opposing Miller's breach-of-contract claim. Second, the record was insufficiently developed on the "solely and directly" issue and a remand to the Plan administrator was necessary for further proceedings on that issue. Third, although language in this court's prior opinion suggested that Miller had satisfied the "total disability" requirement, the district court concluded there

had been no definitive decision on that issue and it should also be addressed on remand. Finally, the district court denied Monumental's motion to strike Miller's motion for attorney's fees, and also denied Miller's motion for fees.

Miller appeals, arguing (1) the district court should not have permitted Monumental to raise the "sole cause" issue for the first time in district court; (2) the remand to the Plan administrator was unnecessary; (3) Miller should prevail on the "sole cause" issue; (4) this court has already determined that Miller met the "total disability" requirement and that issue should therefore not be revisited; and (5) this court should award him attorney's [*6] fees. For its part, Monumental argues that we lack jurisdiction over the order remanding this case to the Plan administrator; that estoppel and waiver did not forbid it from raising the "sole cause" issue; that remand to the administrator was appropriate; and that Miller was not entitled to attorney's fees.

ANALYSIS

As we must, we examine first our jurisdiction to consider this appeal. "Aside from a few well-settled exceptions, federal appellate courts have jurisdiction solely over appeals from *'final decisions* of the district courts of the United States.'" *Rekstad v. First Bank Sys., Inc.*, 238 F.3d 1259, 1261 (10th Cir. 2001) (quoting 28 U.S.C. § 1291) (emphasis added). "A final decision is one that ends the litigation on the merits and leaves nothing for the court to do but execute the judgment." *Id.* (quotation omitted).

In general, a court order remanding a claim to a plan administrator, like an order remanding a claim to an administrative agency, is not a final decision. *See id.* at 1262. Even so, "district court orders remanding an issue to an ERISA plan administrator are not per se nonfinal. The [finality] decision should be made on a case-by-case basis applying well-settled principles [*7] governing 'final decisions.'" *Id.* at 1263.

One concern in assessing finality is whether a remand order's practical effect makes an important legal question effectively unreviewable. *Id.* at 1262. This concern originally arose in administrative agency cases. A district court exercising judicial review sometimes resolved a legal question and then remanded to the agency for further proceedings. Though the agency's decision on remand was often dictated by the district court's legal analysis, the agency was barred from seeking judicial review of what became its "own" decision after remand. Since the agency could neither appeal the non-final remand order, nor appeal from the ultimate disposition of the case, the district court's legal analysis was effectively insulated from appellate review. *Id.* To avoid this problem, courts crafted a "practical finality" rule, which permits appeal of a remand order where an important legal issue exists and the right to appeal would otherwise be lost. Subsequent cases have extended this rule to the ERISA context.

Relying on our practical finality cases, Miller argues that he has presented a legal issue that will, as a practical matter, be unreviewable if he [*8] is not permitted an immediate appeal. This

issue he wishes to preserve through immediate appeal is whether Monumental could raise a "new defense" of "sole cause" at the district court level. Aplt. Reply Br. at 2. Putting aside the fact that our prior decision remanded precisely for a determination concerning this new defense, we find no basis to conclude that a practical finality problem arises here. While it is conceivable that Miller may ultimately convince either this court or the district court that Monumental was barred from raising the "sole cause" defense, the fact that he must wait to do so until proceedings on remand are complete does not make the issue effectively unreviewable. The district court's order clearly contemplates further review in the event that Miller is dissatisfied with the administrator's resolution of this issue.

This case resembles *Garner v. U.S. West Disability Plan,* 506 F.3d 957 (10th Cir. 2007). In *Garner,* we found no appellate jurisdiction where the district court remanded to the plan administrator for further consideration of the plaintiff's claim for disability based on her alleged major depression. We stated:

> To be sure, the inability to appeal at this [*9] stage will compel Ms. Garner to participate in a remand that she contends was improperly ordered, and that burden cannot be fully cured through a later appeal. But courts do not ordinarily treat the burden of having to participate in litigation as one that justifies appeal from a nonfinal order.

Id. at 961.

Moreover, we stated in *Garner* that even if the plaintiff's assertion was correct that the district court lacked jurisdiction to remand to the administrator, there was "no reason to believe that a remand to the Plan at this juncture would prevent us from considering her argument in a later appeal following a final order." *Id.* at 962. Thus, the case did not fall within the "practical finality" rule. *Id.*

The same is true here. Neither the cost or delay associated with additional review of the "sole cause" defense, nor Miller's unfounded fear about loss of his argument that Monumental was not entitled to raise this defense, justifies treatment of the remand order as a final order for purposes of review. Miller's contentions are not "effectively unreviewable."

This appeal is therefore DISMISSED for lack of jurisdiction. We DENY Miller's request for appellate attorney's fees and Monumental's [*10] motion to file a sur-reply brief.

Entered for the Court
Monroe G. McKay
Circuit Judge

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No. 10-427

OCT 26 2010

OFFICE OF THE CLERK

In The
Supreme Court of the United States

RODNEY MILLER,

Petitioner,

v.

MONUMENTAL LIFE INSURANCE COMPANY,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

RESPONDENT'S BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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LIST OF PARTIES

The following list identifies all of the parties appearing here and before the United States Court of Appeals for the Tenth Circuit:

1. Rodney Miller, Petitioner and Appellant below.
2. Monumental Life Insurance Company, Respondent and Appellee below.

CORPORATE DISCLOSURE STATEMENT

Respondent Monumental Life Insurance Company is 100% owned by Capital General Development Corporation. The parent company is not publicly traded. Both Monumental Life Insurance Company and its parent are members of the AEGON Group. The AEGON Group, through its member companies, is a leading international insurance group with its headquarters in The Hague, the Netherlands. The principal market for common shares of AEGON, N.V. is Euronext Amsterdam. Common shares of AEGON N.V. are listed on the NYSE and the Frankfort, London, and Tokyo exchanges as well as the SWX Swiss Exchange.

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STATEMENT

A. Petitioner's ERISA Claim

This case arises from Petitioner's claim for benefits under an ERISA plan (the "Plan") after he allegedly suffered a work-related injury to his back and neck in a motor vehicle accident. Certain of the Plan benefits were backed by an insurance policy issued by Respondent. The Plan did not grant the Plan administrator discretionary authority. Petitioner asserted a claim for Continuous Total Disability ("CTD") benefits under the Plan. To be entitled to CTD benefits, Petitioner had to establish: (a) he was "Totally Disabled" as defined by the Plan,[1] (b) he had been granted a Social Security Disability Award ("SSD Award") by the Social Security Administration ("SSA"), (c) his Total Disability resulted solely and directly from the work-related injury, and (d) the Total Disability was reasonably expected to continue without interruption until Petitioner died. Petitioner submitted to the Plan with his claim for CTD benefits the SSA's decision denying his application for an SSD Award and the SSA's decision conditionally approving his application for a Supplemental Security Income Award ("SSI Award"), along with certain documents he had submitted to the SSA in connection with his application for the SSD and SSI Awards. Petitioner submitted no

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[1] "Total Disability" and "Totally Disabled" are defined in the Plan as the insured being "unable to perform every duty pertaining to any occupation for which he is or may become qualified by education, training or experience."

other evidence establishing the other requirements for CTD benefits under the Plan. Petitioner's claim was denied by the Plan administrator. In the denial letter, the administrator stated the Plan required Petitioner be unable to engage in any gainful employment and be awarded a SSD Award by the SSA for injuries suffered in the work-related accident. The administrator went on to state the information provided by the Petitioner indicated he was awarded an SSI Award and not an SSD Award as required by the Plan.

B. Petitioner's Lawsuit

Petitioner filed a lawsuit for ERISA Plan benefits claiming the Plan administrator's benefit decision was incorrect. In his petition, Petitioner alleged he was entitled to CTD benefits under the Plan as he was disabled "due to the combined effects of chronic back and neck pain associated with facet arthropathy with cervical and lumbar radiculopathy, carpal tunnel syndrome, bi-polar affective disorder and valvular heart disease with valve replacement." He also alleged the SSA's SSI Award made him eligible for CTD benefits under the Plan. Both parties moved for summary judgment. The District Court granted Respondent's summary judgment motion finding the SSI Award did not meet the Plan's requirement for an SSD Award. The District Court did not address the "sole cause" issue (whether any Total Disability resulted solely and directly from a work-related injury) or any other issues. Petitioner appealed.

C. Court of Appeals Reversal

On December 20, 2007, the Tenth Circuit Court of Appeals issued its decision reversing the District Court's summary judgment. The Court of Appeals held Petitioner's SSI Award coupled with the SSA's finding of disability was sufficient to satisfy the Plan's requirement of a SSD Award. The Court of Appeals remanded the case to the District Court to address the "sole cause" issue. Petitioner did *not* appeal this decision of the Court of Appeals, including the Court of Appeals' decision to remand the matter to the District Court to address the sole cause issue.[2] The Court of Appeals' decision became final.

D. District Court Remands Matter

After the case was remanded, Respondent obtained surveillance video of Petitioner[3] that clearly

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[2] It was clear at this point that the District Court would consider a coverage issue at the district court level that was not specifically raised by the Plan administrator at the administrative level and/or that was not clearly set out in the claim denial letter.

[3] In this video, Petitioner is seen approaching the rear of a sports utility vehicle ("SUV"), lifting two 40 pound bags of rock salt (one in each hand) from the back of the SUV and carrying same into the garage of a house. He does this three separate times, each time effortlessly lifting a 40 pound bag of salt in each hand and easily and freely walking and carrying same into the garage. He is also seen vigorously walking, carrying and operating a gas-powered blower and climbing in and out of a sedan. He then undertakes to "detail" the SUV, including bending, stooping and vigorously vacuuming the SUV's front

(Continued on following page)

cast doubts on Petitioner's claim that he is or ever was "Totally Disabled." The parties provided additional briefing on the sole cause issue, waiver, estoppel and the Plan requirements for CTD Benefits. Respondent pointed out that Petitioner had not established the right to CTD Benefits under the Plan. Respondent also briefed the issue of the appropriate remedy and remand to the Plan administrator. The only evidence before the District Court on its *de novo* review was the SSA's decisions on Petitioner's request for a SSD and SSI Awards and the documents associated with Petitioner's request for such Awards.

The District Court held (a) Petitioner had the burden of proving his entitlement to benefits under the ERISA plan, (b) the Court's *de novo* review was restricted to the administrative record, (c) Respondent failed to provide adequate findings and failed to adequately explain the grounds for denial of benefits in the claim denial letter, and (d) such failure did not automatically entitle Petitioner to benefits under the Plan. The Court determined that remand to the Plan administrator was the appropriate remedy. The District Court also held that principles of waiver and estoppel could not be used to modify the express terms of the ERISA Plan and that on remand to the

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and rear floors, scrubbing floor mats, scrubbing the sides of the SUV, climbing up a ladder to scrub and wash the top of the SUV while standing at the top of the ladder and easily reaching across the top of the SUV, and scrubbing and cleaning the inside of the SUV.

Plan administrator, Petitioner had the burden to establish that he was entitled to the benefits under the Plan's terms, including the requirement to show he was "Totally Disabled" as defined by the Plan and that any Total Disability resulted solely and directly from a work-related injury.

E. Petitioner's Second Appeal

Petitioner appealed the District Court's order remanding the matter to the Plan administrator. On April 28, 2010, the Court of Appeals issued its decision dismissing Petitioner's second appeal for lack of jurisdiction. The Court of Appeals set out the parties' contentions, including Respondent's assertion that the Court of Appeals lacked jurisdiction over the District Court's remand order. The Court of Appeals first addressed the jurisdictional issue discussing 28 U.S.C. § 1291, Tenth Circuit case law requiring a case-by-case analysis, and the Tenth Circuit's "practical finality" rule (under this rule, a district court's remand order is a final order if the order's practical effect makes an important legal question effectively unreviewable). The Court concluded the District Court's order remanding the case to the Plan administrator was not a final decision and, thus, the Court of Appeals lacked jurisdiction. The Court of Appeals dismissed the Appeal.

F. Petition for Writ of Certiorari

In his Petition for Writ of Certiorari, Petitioner claims the Court of Appeals' decision creates "a clear

circuit conflict." Petitioner then identifies what he perceives as this "clear circuit conflict" – whether an ERISA plan administrator can support its claim denial at the district court level based upon other coverage provisions not fully explained in the administrator's denial letter or not reached by the administrator, and in such situations, whether the administrator is estopped to require or can waive the Plan requirement that the claimant establish the right to receive plan benefits. However, while the Court of Appeals identified this issue as one raised by Petitioner, it did not rule on this or any other substantive issue. Rather, as noted above, the Court of Appeals dismissed the appeal for lack of jurisdiction finding the District Court's order remanding the matter to the Plan administrator was not a final decision under 28 U.S.C. § 1291 and Tenth Circuit's case law interpreting this statute.

SUMMARY OF THE ARGUMENT

Contrary to Petitioner's assertion, this case does *not* present an issue of an ERISA plan denying a benefit claim at the administrative level for one reason and then the district court upholding the claim denial based upon a different reason first raised by the plan administrator at the District Court level. The District Court in this case did *not* uphold Respondent's claim denial. Rather, the District Court found procedural irregularities and/or violations by the Plan administrator and remanded the matter to

the Plan administrator giving Petitioner a full opportunity to establish coverage and his entitlement to the Plan's CTD Benefits. The opinion of the Court of Appeals from which Petitioner files his Petition did *not* decide any issue other than a jurisdictional issue.

The threshold question presented is whether the order of the District Court was an appealable order and whether this case was properly "in the Court of Appeals" under 28 U.S.C. § 1254 when the Petition for Certiorari was filed in this Court. *U.S. v. Nixon*, 418 U.S. 683, 690 (1974). The Court of Appeals' jurisdiction under 28 U.S.C. § 1291 encompasses only "final decisions of the district courts." Petitioner's Writ of Certiorari is not properly before this Court for consideration as the District Court's order was not a final decision. *Nixon, supra*. Furthermore, this case does not fit into the "limited class of cases where denial of immediate review would render impossible any review whatsoever of an individual's claims." *Nixon, supra*.

The Court of Appeals correctly concluded that the District Court's Order remanding the matter to the Plan administrator was not a final, appealable decision. The Court of Appeals correctly concluded that the remand Order did not make any important legal question effectively unreviewable under the Tenth Circuit's "practical finality" rule (the "practical finality" rule is similar to this Court's "collateral order" doctrine). Furthermore, the issue of whether the Plan administrator could at the District Court level raise coverage issues if such issues were not fully explained

in the claim denial letter was *not* ruled upon by the Court of Appeals in its latest decision and, thus, is not properly before this Court.[4]

The issue Petitioner raises in his Writ – whether Respondent can, *at the District Court level*, rely upon the coverage issues to uphold the claim denial when same were not clearly articulated as reasons in the claim denial letter, was not decided by the Court of Appeals. Furthermore, the District Court did not uphold the Plan administrator's claim denial based upon a coverage issue not fully explained in the claim denial letter. Rather, the District Court remanded the matter to the Plan administrator to allow Petitioner to present evidence and the Plan administrator to consider whether Petitioner established his entitlement to CTD Benefits under the terms of the Plan. Remand to the Plan administrator was the proper remedy as the evidence before the District Court did not establish that Petitioner was entitled to CTD Benefits under the Plan and the District Court found various procedural irregularities, including the claim denial letter failing to provide adequate findings and to adequately explain the grounds for denial of Petitioner's claim for CTD Benefits.

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[4] To the extent this issue was ruled on in the Court of Appeals' first decision, Petitioner did not appeal that decision and it became final.

ARGUMENTS

A. Jurisdiction and 28 U.S.C. § 1291

The Court of Appeals properly relied upon 28 U.S.C. § 1291 and Tenth Circuit case law in holding the District Court's remand order was not a final decision and, thus, the Court of Appeals was without jurisdiction. The Court of Appeals properly dismissed Petitioner's appeal.

Section 1291 provides that the courts of appeals shall have jurisdiction of appeals "from all final decisions of the district courts of the United States." Under this statute, appeals before the end of district court proceedings "are the exception, not the rule." *Johnson v. Jones*, 515 U.S. 304, 309 (1995). Through practical construction, this Court has crafted a narrow category of prejudgment orders that are immediately appealable under the "collateral order" doctrine. *Behrens v. Pelletier*, 516 U.S. 299, 305 (1996). Under this doctrine, orders that "finally determine claims of rights separable from, and collateral to, rights asserted in the action, too important to be denied review and too independent of the cause itself to require that appellate consideration be deferred until the whole case is adjudicated" are immediately appealable. *Cohen v. Beneficial Industrial Loan Corp.*, 337 U.S. 541, 546 (1949). The requirements for collateral order appeal are that an order "(1) conclusively determine the disputed question, (2) resolve an important issue completely separate from the merits of the action, and (3) be effectively unreviewable on appeal from a

final judgment." *Will v. Hallock*, 546 U.S. 345, 349 (2006).

In the instant case, the District Court's remand order does not conclusively determine a disputed issue and is not effectively unreviewable on appeal from a final judgment. The order remanding the matter to the Plan administrator does not prevent Petitioner from returning to the District Court should he be dissatisfied with the Plan administrator's decision on remand or from raising in the District Court at such time the very issues he now raises. As the Court of Appeals determined, the remand to the Plan administrator does not prevent eventual and effective appellate review of Petitioner's contentions that Respondent waived the requirement that he establish that he is entitled to the CTD benefits under the Plan or that Respondent is estopped to raise such requirements by not specifically raising his failure to establish these Plan requirements in the initial claim denial letter.

B. Finality of Remand Orders

This Court recently denied Writ of Certiorari in a Tenth Circuit case wherein the Court of Appeals held the District Court's order remanding a case to an ERISA plan administrator was *not* a "final decision of the District Court" under § 1291. *Graham v. Hartford Life & Accident Ins. Co.*, 501 F.3d 1153, 1154 (10th Cir. 2007), *cert. denied*, ___ U.S. ___, 128 S.Ct. 1650, 170 L.Ed.2d 354 (2008). In *Graham*, the Court of

Appeals quoted § 1291 stating a "final decision" was one that "ends the litigation on the merits and leaves nothing for the court to do but execute the judgment." *Id.* at 1156 (*quoting Rekstad v. First Bank Sys.*, 238 F.3d 1259, 1261 (10th Cir. 2001) (*quoting Catlin v. United States*, 324 U.S. 229, 233 (1945))). The Court went on to discuss the Tenth Circuit's case-by-case approach, the "practical finality rule" and the "comparatively strict collateral order doctrine" utilized by other circuits. Under the "practical finality rule," the Court will review an order remanding a matter to an administrative agency when it is necessary to ensure that the court can review important legal questions which a remand may make "effectively unreviewable," because administrative agencies "may be barred from seeking district court (and thus circuit court) review of their own administrative decisions." *Graham,* 501 F.3d at 1158. The Court applied the practical finality rule and held the District Court's remand order was not a final decision ending the litigation on the merits.

Other Tenth Circuit cases have also held District Court remand orders were not final decisions under § 1291. *Garner v. U.S. West Disability Plan*, 506 F.3d 957 (10th Cir. 2007); *Metzger v. UNUM Life Ins. Co. of Am.*, 476 F.3d 1161 (10th Cir. 2007); *Caldwell v. Life Ins. Co. of N. Am.*, 287 F.3d 1276, 1288 (10th Cir. 2002); *Rekstad v. First Bank System, Inc.*, 238 F.3d 1259 (10th Cir. 2001).

Other Circuit Courts have likewise held that an order remanding an ERISA case to a plan administrator for further consideration is not a final appealable

judgment. *See Petralia v. AT&T Global Information Solutions Co.*, 114 F.3d 352 (1st Cir. 1997); *Bowers v. Sheet Metal Workers' Nat'l Pension Fund*, 365 F.3d 535, 536 (6th Cir. 2004); *Borntrager v. Central States, Southeast and Southwest Areas Pension Fund*, 425 F.3d 1087 (8th Cir. 2005); *Abram v. Cargill, Inc.*, 395 F.3d 882, 886 (8th Cir. 2005) ("A reviewing court must remand a case when the court or agency fails to make adequate findings or explain the rationale for its decision."); *Shannon v. Jack Eckerd Corp.*, 55 F.3d 561 (11th Cir. 1995).

The Seventh and Ninth Circuits hold appeal may be appropriate in certain circumstances. *See, Hensley v. Northwest Permanente P.C. Ret. Plan & Trust,* 258 F.3d 986, 992-93 (9th Cir. 2001); *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 979-80 (7th Cir. 1999). The Second Circuit has not decided on the issue. *Giraldo v. Building Service 32B-J Pension Fund*, 502 F.3d 200, 202 (2nd Cir. 2007).

C. Remand Not Practically Final

The Court of Appeals correctly held that the District Court's order remanding the matter to the Plan administrator was not a final decision under § 1291 and the "practical finality" doctrine. The Court of Appeals correctly found that the issue asserted by Petitioner – whether Respondent could raise coverage issues that were not clearly and specifically addressed by the Plan administrator in its initial denial

letter – was not effectively unreviewable. The Court of Appeals correctly pointed out that if, on remand, the Plan administrator denied Petitioner's claim for CTD Benefits based upon coverage issues not clearly and specifically discussed in the initial claim denial letter, then judicial review of such decision, as well as whether the Plan administrator was allowed to rely upon these coverage issues, was available to Petitioner. In that the remand order was not a final decision and was not practically final, the Court of Appeals properly dismissed the appeal for lack of jurisdiction.

D. Other Tenth Circuit Cases

Petitioner states that the District Court and Court of Appeals' decisions in this case are in conflict with the Tenth Circuit's decision in *Flinders v. Workforce Stabilization Plan of Phillips Petroleum Co.*, 491 F.3d 1180 (10th Cir. 2007). However, a review of the *Flinders* case reveals it in no way supports Petitioner's position, and, in fact, supports the District Court's rulings in this matter, including the remand of this matter to the Plan administrator.

In *Flinders*, employees covered by two collective bargaining agreements sought certain benefits provided to the company's employees under a certain workforce ERISA plan ("WFSP"). The plan administrator denied the employees' claim asserting there was no reference to or inclusion of the WFSP in the collective bargaining agreements, as specifically required by the WFSP for payment of the benefits

sought by the employees. The employees filed suit. In an attempt to support its denial at the district court level, the plan relied upon an additional reason for denial claiming the WFSP was not "a plan arranged by the Company for its employees" and therefore was not included in the collective bargaining agreements. The District Court relied upon this reasoning in granting summary judgment. The Court of Appeals reversed holding the plan administrator violated ERISA in asserting this additional reason for denial and the District Court erred in granting summary judgment based upon this reason. The Court of Appeals then addressed the reason given by the administrator and concluded such reason was not supported by the language of the plan, and that under the plan's unambiguous language, there was reference to and inclusion of the WFSP in the collective bargaining agreements.

The *Flinders* Court then addressed the issue of the *appropriate remedy*. The Court stated it could "either remand the case to the plan administrator for a renewed evaluation of the claimant's case" or "order an award of benefits." If the plan administrator failed to make adequate factual findings or failed to adequately explain the grounds for the decision, then the proper remedy was to remand the case for further findings or additional explanation. However, "if the evidence in the record clearly shows that the claimant is entitled to benefits, an order awarding such benefits is appropriate."

The *Flinders* Court specifically stated that while it did not consider the plan's additional reason *in deciding whether to uphold the District Court's summary judgment* for the plan, the Court **could not "ignore it for purposes of formulating an appropriate remedy"** and that it was not "this Court's function *ab initio* to apply the correct standard to the participant's claim." The Court then addressed in detail why and how the evidence clearly established that the WFSP was "arranged by the Company for its employees" and how it would be patently unreasonable for the plan to deny benefits on the basis that the WFSP was not arranged by the Company for its employees. The Court concluded that the plan's position on this issue was "untenable," that it would be "unreasonable" to deny benefits based upon this ground, and there was no point in remanding the case so that the Plan could again deny benefits, only to be reversed a second time on appeal. The *Flinders* Court concluded that the case before it was one where a remand was unnecessary and an award of benefits was appropriate as the plaintiffs had shown and the evidence established their entitlement to same.

Nowhere in *Flinders* did the Court state or hold that the plan administrator was estopped to raise or waive the requirements of the ERISA plan for benefits. In fact, the *Flinders* Court fully considered the merits of the issue that was first raised by the plan administrator at the district court level. In that the evidence clearly refuted this "additional" reason for denial of the claim, the *Flinders* Court determined

remand was not necessary. Nowhere in *Flinders* did the Court state that an ERISA plan participant is entitled to plan benefits without meeting the requirements clearly and unambiguously stated in and required by the plan for such benefits. In the case at bar, remand was necessary for the development and consideration of additional evidence on the issue of Petitioner's entitlement to CTD Benefits. The remand affords Petitioner a full opportunity to present any and all evidence to support his claim for CTD Benefits under the Plan. The decision in *Flinders* fully supports the District Court's remand of this matter to the Plan administrator.

Other Tenth Circuit cases have likewise held the appropriate remedy is to remand the matter to the plan administrator. *Scruggs v. ExxonMobil Pension Plan*, 585 F.3d 1356 (10th Cir. 2009); *DeGrado v. Jefferson Pilot Financial Ins. Co.*, 451 F.3d 1161, 1175 (10th Cir. 2006); *Caldwell v. Life Ins. Co. of North Am.*, 287 F.3d 1276, 1288 (10th Cir. 2002). In *Scruggs*, the Court stated the district court was "vested with discretion to remand a case to the plan administrator for a renewed evaluation of the claimant's case." *Id.* at 1360. The Court held the district court could remand the matter to the plan administrator for *de novo* review and, in doing so, "the plan administrator was specifically authorized by the district court to present alternate reasons for denial in its re-evaluation of plaintiff's claims." *Id.*

Other Courts agree with the remedy available to a district court under such circumstances. *Gallo v.*

Amoco Corp., 102 F.3d 918, 923 (7th Cir. 1996) (a remand for further action is unnecessary only if "the case is so clear cut that it would be unreasonable for the plan administrator to deny the application for benefits on any ground"); *Hackett v. Xerox Corp. Long-Term Dis. Inc. Plan*, 315 F.3d 771, 776 (7th Cir. 2003) (remand is proper; plan administrator's failure to provide adequate findings or to explain the grounds for denial of benefits "does not mean that claimant is automatically entitled to benefits because such a holding might provide the claimant with an economic windfall should she be determined not disabled upon a proper reconsideration."); *Weaver v. Phoenix Home Life Mut. Ins. Co.*, 990 F.2d 154, 159 (4th Cir. 1993).

DISTRICT COURT – REMAND COURT OF APPEALS – NO JURISDICTION

In the instant case, the District Court properly remanded the matter to the Plan administrator. The Court of Appeals properly determined it was without jurisdiction in that the District Court's remand order was not a final decision under 28 U.S.C. § 1291 and Tenth Circuit case law. This was the only decision made by the Court of Appeals. The Court of Appeals did not decide or rule on whether or not the remand for reconsideration of Petitioner's entire claim was appropriate or what the Plan administrator could or could not raise or consider on remand. The Court of Appeals simply and correctly held it was without

jurisdiction under 28 U.S.C. § 1291. Thus, this matter was not properly "in the Court of Appeals" under 28 U.S.C. § 1254, and Petitioner's Petition for Writ of Certiorari should be denied.

CONCLUSION

The Petition for Writ of Certiorari should in all things be denied.

Respectfully submitted,

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